**NEW ZEALAND HEALTH STRATEGY 2015**

**CONSULTATION SUBMISSIONS**

**276 – 295**

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Please indicate which sector(s) your submission represents
*(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

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[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

[ ]  Professional association

[ ]  Academic/research [ ]  Other *(please specify)*:

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| In a time when the health sector’s greatest challenge is the increasing inequity in health status and services obtained across our society, many in the sector, especially those working in public health, including public health nurses, already strive to address determinants of health through collaboration across sectors and ‘join up’ different parts of the health service and other social services for those in greatest need. The challenge is to have all levels of all sectors highly motivated to collaborate, as currently there remains significant barriers between sectors as each has its own priorities it is required to meet with limited resources.If there is to be a renewed focus on health promotion and illness prevention, and on understanding populations and their needs, then it is not sufficient to respond to observed behaviours and outcomes, but to identify why different populations behave as they do.  |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| …providing services closer to **where people live, work and learn**Our experience is that many people, especially those in insecure, low-paid employment, who most need to access primary care services are unable to do so because of long hours worked far from where they live. For many students, schools and tertiary institutions (and even early childhood education centres), are already an essential venue for primary care. This could be developed further.The draft revised Strategy does not make clear whether the **one team** includes working with other sectors. As the impression in the Strategy document is for greater collaboration with other participants, this may need to be made more explicit  |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| We very much welcome the public/population health focus of the principles. We suggest rewording of Principle 5 to stress equitability of access to services: Timely and equitable access for all New Zealanders to ***the same quality***comprehensive range of health and disability services, regardless of ***domicile******and*** ability to pay Stronger collaborative partnerships to make any significant impact on determinants of health will require strong leadership and facilitation at all levels of the health sector and a mandated willingness by other sectors to participate. |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| While the principles have a focus on the promotion of health and wellbeing, and the prevention of ill health, it is disappointing that much of the description of each of these themes is, to a large extent, about treatment rather than enabling. *People power*We agree the importance of understanding people’s needs and working with them so that they get the information and services they need to maintain and improve their health. This requires a real understanding of why people and groups behaviour the way they do. It is necessary to understand how their needs, interests and priorities are arrived at.We support the notion of people being enabled to have control over their health and that the role of health services is the work *with* them to achieve this.*Closer to home*A focus in this section on investment in the health and wellbeing of children and young people is very reassuring to see. We absolutely agree with the need for better integration within the health sector and of the health sector with other sectors that have jurisdiction over determinants of health, as this is especially essential in order to meaningfully address disparities in child health statistics. We were disappointed that nurses were not included among ‘practitioners’ in the box on Children’s teams (p.16) given that nurses are the health workers most often encountered by families with young children.We recognise that health information and services need to be available closer to where people live, work and learn and strongly support this. This should also include times when people can access them. Low-paid workers, in particular, are tied to low paid, insecure jobs with little flexibility for taking time away for health care needs during working hours. *Value and high performance*We absolutely agree that the health system, and the rest of the public sector, needs to prioritise efforts to address health disparities within the population, and we agree with the need for a focus on results which demonstrate this. But these have tended to be counted in terms of outputs and short term outcomes. There is a need for clear, measureable and meaningful targets. *One team*We agree that there is a need to reduce fragmentation of services and the significant adjustment by leaders at all levels of the health system to achieve this. Alongside this is the need for consistency and sustainability. People often miss out on health information and services when service providers and ways of providing services change and cause uncertainty.  |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| There is a lack of coherency between the strategy’s stated principles and the Road Map. The results (Fig. 11) are very light on the’ live well, stay well’ end of the continuum with most of the results focus on ‘getting well’. The results also fail to reflect the strategy of addressing the determinants of health through greater integration and collaboration across sectors. Without explicit results/targets (and leadership) there is unlikely to be much meaningful movement on this as sectors with tight resourcing focus on what they perceive as their own business.We strongly agree that information and services requires regular review to meet the needs of populations so that they are motivated to access and use these, however, care should be taken to avoid constant changes which can create confusion and alienation for those most needing to remain connected to services. Our experience is that vulnerable populations need consistency from providers. We support the statement that there is urgent need for a more effective, integrated, multi-sector effort to address the health and health determinant needs of Aotearoa New Zealand’s vulnerable population, particularly children and youth and their families and whanau.We fully support Action 6: Greater start for children families and whanau in its entirety. We would add to h. …*and other developmental and behavioural disorders.*  Given the increasing number of children referred, usually through schools, who’s learning and social wellbeing is significantly disrupted and disruptive. For many of these children foetal alcohol spectrum disorder is not a diagnosis.There is certainly a need for better integration and cohesion within the health system but the One Team action area is likely to be constrained because Ministry contracting models discourage this and make for a competitive environment. |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| Public Health approaches need to be significantly more prominent in the Roadmap of Actions, with evaluation built into programmes from the onset so that tracking progress is, ‘business as usual’. Approaches must include the use of Pacific and kaupapa Maori models if equity in health and wellbeing is to achieved in Aotearoa New Zealand |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| Given the strategy goal and the Principles for guiding strategy, we would have expected to see reference to the Ottawa Charter. Te Whare Tapa Wha model of health has particular relevance in the Aotearoa New Zealand setting. Cherry-picking data in order to demonstrate health sector performance does not truly reflect the poor and inequitable performance around on a significant number of health indicatorsThe use of a number of technical, economic-speak phrases such as *end-to-end journey* and  *health investment approach* are likely to have reduced readability to this document for some who lay people. |

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| **277** | Submitter name | [redacted] |
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Smokefree Coalition’s submission in response to the Update of the New Zealand Health Strategy Consultation **draft**

*Submission prepared by* [redacted]*, Executive Director*

**Introduction:**

Thank you for this opportunity to make a submission on the New Zealand Health Strategy. The Smokefree Coalition is a united voice for action towards achieving the Smokefree 2025 Goal. It has over 50 organisational members representing a broad and diverse health care workforce committed to increasing successful cessation and increasing public support for greater tobacco control measures.

Since March 2011 the government’s commitment to making Aotearoa New Zealand a Smokefree nation by 2025 has encouraged the tobacco control sector to refocus its programme of action to rise to this challenge. This was an affirmative response to a comprehensive report of the Maori Affairs Select Committee, on the tobacco industry in Aotearoa New Zealand and the consequences of tobacco use for Maori. This report made clear that to achieve this ambitious goal, new and innovative measures were needed that would empower more smokers to break free from tobacco addiction. Without innovations and a targeted approach to our tobacco control programme, inequities between Maori and non-Maori New Zealanders caused by tobacco use would continue, and the <5% prevalence goal of the nation would not be achieved.

New Zealand has received global recognition for its innovative approach and leadership in tobacco control. It was one of the first nations to endorse the Framework Convention on Tobacco Control, and since 2011 has had government commitment to making the nation Smokefree before 2025. There has been significant progress toward this goal:

* with the introduction of targets throughout primary and secondary care
* new funding for piloting and evaluating innovative cessation programmes
* new funding for building evidence toward further tobacco control interventions
* legislation to ban tobacco within retail display
* legislation to reduce duty-free quotas for entry of tobacco into the country
* annual tobacco excise tax increases
* standardised packaging of tobacco products

Robust modelling of prevalence rates to 2025, however, indicate that all of the above efforts are still not enough to achieve the Smokefree 2025 goal. More must be done to de-normalise tobacco use by restricting supply and reducing visibility. We have been promised that separate tobacco control roadmap is to be developed: we consider that that biggest deficit of the draft Health Strategy is that it fails to adequately address New Zealand’s biggest killer, tobacco.

### Challenges and opportunities

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

There is no reference within the discussion to the government’s goal of a Smokefree Aotearoa by 2025, even as an aspiration. Such a commitment should be included as a key opportunity for our sector to strategize measures to

* reduce tobacco related harm and disease across our communities,
* adequately fund cessation services and treatments, and
* prevent uptake of smoking among children.

Priority should be given to the third of these points, with emphasis upon the children of current New Zealanders who smoke. For example, an action in the Health Strategy could be to increase support for the promotion of smokefree environments where children are.

Prevalence and consumption of tobacco tells an adult story about smoking. But the impact of smoking prevalence and consumption is largely upon unequally exposed children, who not only suffer and die (sometimes before they are born) from the effects of secondhand smoke, but grow up in an environment where tobacco is normalised by their caregivers. The Smokefree Coalition requested data from the 2013 Census for the number of dependent children living in households where at least one adult resident smoked. This data found 602,500 dependent children, or up to 60% of all New Zealand children, lived in households where there was potential exposure and normalisation of smoking by their caregivers. Nothing in the draft Health Strategy addresses this story of exposed children and the huge health risk to their longterm wellbeing.

### The future we want

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

The term “all” is not reflected adequately in the discussion nor the roadmap. “All” indicates that these actions are universally applied, and yet the strategy makes clear it intends to emphasise services to people most in need with this strategy. While we agree with the intent of this word, it is not consistent with the content of the strategy.

The Smokefree Coalition recommends:

So that **all** New Zealanders **are born well, are served well through life, then die well…**

This statement of intent would more adequately encompass the great challenges we have in insuring our services can create for future generations the best possible start to life, beginning with targeted cessation services and adequately funded health promotion to support smokefree pregnancy, cars and homes. This new statement gives emphasis to staying well through life and the quality of life that living healthy affords New Zealanders. It also acknowledges New Zealand’s aging population and their needs, despite the suggested refocus on the start to life.

The Smokefree Coalition cannot support this value statement’s prioritisation of “home” when there is such a housing crisis in New Zealand, and for many more New Zealanders, their home is not a safe environment, and/or not a healthy one.

The Smokefree Coalition does however fully support the prioritisation of “working as one team within a smart system” and encourages all sectors to look closely at the success of our tobacco control sector in this regard. In the spirit of one national coalition, we have built strong collaborative leadership through a National Smokefree Working Group, and alliances across all DHBs with the NGO sector via regional coalitions, and progress reported against a Smokefree National Action Plan. With minimal funding for health promotion and advocacy, our emphasis is on relationships and collaborating strategically through national information services disseminated cost-effectively via regional network champions.

The only reason why this Health Strategy would need to reinvent the wheel on value and high performance is because it risks ignoring the great value for money and high performing network in tobacco control, developed largely outside of government and despite the lack of a tobacco control action plan.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

The principles outlined are aspirational (like the commitment to a Smokefree Aotearoa by 2025) and require clearer measurable outcomes to identify meaningful change that can be achieved and sustained.

* The best **health and wellbeing** possible for all New Zealanders **throughout their lives.** This principle needs to include a commitment to the promotion of health literacy with individuals, families, communities and professional networks.
* Thinking beyond narrow definitions of health and **collaborating with others** to achieve wellbeing. This needs a multi-agency commitment, recognising the importance of the NGO sector, professional networks and forums (especially Smokefree Coalitions operating throughout New Zealand) and Territorial Local Authorities as key service providers seeking to gain community outcomes (alignment with health and wellbeing). Also relevant for Active **partnership** with **people and communities** at all levels. Appropriate forms of capacity building opportunities to encourage participation in decision making.

### Five strategic themes

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

There should be included specific objectives to reduce tobacco related harm for individuals, families and communities.

### Roadmap of Actions

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

The environment is not adequately addressed as a determinant of health outcome in this strategy. Health promotion and advocacy needs adequate funding to

* expose the rogue industries within New Zealand that promote dangerous / addictive products to children
* build public support for a comprehensive government programme of regulatory interventions

There is but one reference to Smokefree homes promotion on point c of Action 6: this is inadequate and we recommend a comprehensive tobacco control response to both the private, public and online environments of children and ways that tobacco is still being normalised within them.

We support action 8, to develop and implement a health outcome focused framework, so long as it emphasises measures to reduce supply and demand for tobacco through adequately funded health promotion and tobacco control advocacy.

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

Tracking and reporting progress needs independent research, which needs adequate funding. There should be an alliance between government, the NGO sector, and research units across New Zealand, to develop an outcomes evaluation plan that allocates funding of research in specific health outcomes to their relative NGO, while in health service outcomes to each DHB. For example, the Asthma Foundation has recently launched its Respiratory Health Strategy: ongoing research on respiratory health in New Zealand must be resourced adequately and independently through this Foundation’s funding, to track progress against this collaborative approach to improving health literacy and services to sufferers of respiratory disease in New Zealand.

### Any other matters

7 Are there any other comments you want to make as part of your submission?

The Smokefree Coalition acknowledges and supports the submission made by its member the Public Health Association, which comments on the Health Strategy with broader focus, on behalf of the wider public health needs of New Zealand.

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| **278** | Submitter name | Professor Jenny Carryer |
| Submitter organisation | College of Nurses Aotearoa (NZ) Inc |



**College of Nurses Aotearoa (NZ) Inc**

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4 December 2015

New Zealand Health Strategy Team

Ministry of Health

PO Box 5013

Wellington 6145

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On behalf of College of Nurses Aotearoa (NZ) Inc we thank you for the opportunity to feedback on New Zealand Health Strategy Update Consultation.

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| --- | --- |
| This submission was completed by:  | Professor Jenny Carryer |
| Email: | admin@nurse.org.nz |
| Organisation (if applicable): | College of Nurses Aotearoa ( NZ) Inc |
| Position (if applicable): | Executive Director |

Are you submitting this *(tick one box only in this section)*:

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**Challenges and opportunities**

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| The strategy seems very short of actual population health goals and there is almost no evidence of planned actions to address the major preventable causes of poor health and premature death. These would seem to be significant concerns if the strategy is indeed aimed to enable New Zealanders to “live well, stay well and get well”.Overall there is an excessive focus on the “treatment of illness system” as a supposed means of keeping people well. This is exemplified at the very start of the strategy when the number of GP visits is listed as evidence of success. |

**The future we want**

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

1. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| There is considerable similarity between this statement and the statements that underpinned the release of the Primary Health Care Strategy in 2001. We have no argument with the expressed goals but believe there should be much greater critical reflection as to why we are needing to repeat these goals nearly 15 years later. Such words are very easy to write but require courage and an overthrow of traditional allegiances and power bases in order to genuinely work towards such goals. |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

1. Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| The College most certainly agrees that these are the right principles for the New Zealand health system and that they are the appropriate goals to guide the implementation of the Strategy. However our comments above still stand. Historical funding models have tended to support a downstream and reactive focus to illness care.  That is they have focused on the 'tyranny of the acute' without managing to reduce the overall long term demand. In order to re-design funding models that support new ways of operating we need the MoH and DHB's to ensure that vested interests do not continue to hold sway in consultation processes and that there is genuine and transparent consultation with those whose focus is on embedding community wellness rather than treating illness in a downstream manner.  |

**Five strategic themes**

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

1. Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| In order to actualise these important themes our comments as above apply again. |

**Roadmap of Actions**

II. Roadmap of Actions has 20 areas for action over the next five years.

1. Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| The actions in themselves are appropriate but without a concerted effort to avoid oldpatterns and pathways they will not be successful.As an example we note the statement on Page 21: **“It is important that we have a workforce whose size and skills match New Zealand’s needs. Going forward, this will mean the development of new or stronger skills for some, especially those supporting integrated care that work in teams with a range of health specialties. There is also a need to enable flexible and full use of skills, and this will mean continuing to reduce the barriers that currently prevent this, including legislative barriers”**We agree that workforce will be critical to the success of the strategy refresh. It will be vital to pay more than lip service to this particular goal. Every health professional should be able to use their skill set, knowledge base and expensive training to the fullest advantage. The findings of the recent Physician Assistant trial would suggest strongly that GPs in particular are being paid to do a great deal of work that could quite clearly be done by others. Accordingly we should be considering how much they could alleviate the shortages of specialist positions in areas such as dermatology and many others. At the same time it will be essential to ensure that nurses and nurse practitioners are actually free to deliver the services of which they are more than capable. GP employment of practice nurses often acts as an impediment to this as GP’s business agenda places artificial and non patient centred constraints on nurses’ practice.We also note the statement on Page 22: **This Strategy places particular emphasis on integration, which is critically dependent on a team approach.** We strongly support the focus on integration. Many of us have however observed that contracts, funding and historic processes actively work against effective integration. It will take concerted effort to remove those obstacles.On Page 26 the document notes: **New Zealanders make regular and effective use of a patient portal to access their health information and improve their interactions with their doctor and other health care providers**This statement exemplifies our concerns. Alongside our NPNZ colleagues we suggest this is worded “improve their interactions with their health care professional and health care providers”. The Ministry has always struggled with the avoidance of medico centric language which is a powerful impediment to supporting the very changes this strategy suggests. Language is always important for creating expectations and cementing old ways of behaving.On page 35 we note the statement: **“help people in the health workforce undertake tasks they are skilled (or can be trained) to do that have traditionally been outside their roles”.**Yet again this requires courage and focus. The words are easy to say but the Ministry of Health should consider the extensive delay that has occurred to enabling for example Nurse Practitioners to carry out the very processes for which they are legally authorised and which in many instances persist to this day. There are also examples of the creation of new barriers through failure to consider and consult outside the traditional power structures. Without careful attention to such processes we will continue to see slow progress towards the necessary changes. |

**Turning strategy into action**

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| No comment |

**Any other matters**

7 Are there any other comments you want to make as part of your submission?

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| We think there is a general theme in our feedback which is worth summarising.The transition from words and rhetoric to successful action will be difficult and will require courage and conviction.Traditional power structures will not achieve the desired change.The operational issues must directly support the vision at all levels.People centred care begins with co-design is integral to people centred care and requires an understanding of what matters most to them as individuals, hapu, iwi and communities. Critical to effective engagement in co-design is personal capability underpinned by health literacy, social determinants and the ability to self-determine health outcomes. Co-design is about working ‘with’ and not ‘doing to’. |

Sincerely



Professor Jenny Carryer RN PhD FCNA(NZ) MNZM

Executive Director

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| **279** | Submitter name | Sandra Kirby |
| Submitter organisation | Arthritis New Zealand |

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| Position (if applicable): | CEO |

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### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| We at Arthritis New Zealand endorse the comments that health is wider than the health system that are made on p3 “This Strategy is focused on health but is set within this wider context of the interconnections between health and other aspects of people’s lives”. We are encouraged by the sentiments but cannot clearly see how the integration across other government departments might happen outside of data sharing. For example participation in the workforce and/or community activities is shown to have better health outcomes for people with long term conditions but to achieve this requires cross sector initiatives from Health and Ministry of Social Development – there is scant evidence of these happening or being planned.  |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| While the statement can be seen as aspirational it also is open to interpretation that may not be within the available health budgets.For people with arthritis to **live well, stay well, get well** –could indicate that the PHARMAC model of providing pharmaceuticals within the available budget will be changed. Many New Zealanders with inflammatory arthritis would be able to get well sooner, live well and stay well if they had earlier access to biologic agents that are proven to reduce joint damage and improve quality of life. However our pharmaceutical prioritising has these drugs available as a last resort and when disease is well established. It also currently limits the number of biologic agents – so we could expect a greater range of funded treatments and a change to the PHARMAC model? For people with osteoarthritis to **live well, stay well get well** – early funded access to physiotherapy, self management education and elective surgery would all need to be included.If this is not an intended outcome of the strategy we would suggest a qualifier such as “**within available resources”** is added.Stay well and get well does not resonate with all audiences. For some getting well is not a reality - this appears to be overlooked in the statement. As read this implies that the Ministry of Health is planning on investing heavily to have people live well, stay well get well which has significant implications for resource allocation. As an NGO we are not certain that the **one team** includes the community sectorWhile there is a tension between creating a vision statement that is not cumbersome words like “a range of services working collaboratively to provide services closer to home” does not clearly identify that the range of services includes primary health care, secondary services and community providers let alone the wider range of services such as housing; social services etc. |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| See note above regarding qualifiers Eg – is it possible to fund “The best **health and wellbeing** possible for all New Zealanders **throughout their lives “?**We would also submit that the order should reflect the importance of the Treaty of Waitangi – 4th out of 8 is not a cornerstone principle.Reducing health inequalities follows naturally – recognising that Māori are not the only population where health inequalities exist. |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| It is heartening to see musculoskeletal conditions included in the list of long term conditions. We regard this as essential, based on the number of people living with one or more musculoskeletal conditions; the burden of disease and the projections for an increase in these conditions. In addition musculoskeletal conditions are often the hidden comorbidity to other chronic health problems. |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| We are limiting our comments to Action 5As above musculoskeletal conditions must be included in the list of long term conditions. We strongly disagree with the approach of “ starting with a focus on one of these; for example, diabetes or mental health conditions or cardiovascular disease” This approach was taken when the first health priorities were designed in 1991 – mental health, CVD and diabetes were then chosen as the first of the long term conditions to be prioritised with the belief that these would be managed and then the next ones could become a focus. It won’t happen. Need a range of programmes that address prevention across all (eg preventing/reducing obesity and increasing daily exercise are known preventative strategies for a range of long term conditions) AND specific programmes for the range of conditions. We believe this should be evidence based – address the largest contributors to the burden of disease and/or the conditions that affect the greatest numbers of people.None of the strategies clearly articulate the place of, or funding for, NGO services  |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| It is not clear how the current DHB targets link to this strategy or whether targets will be reviewed to come in line with the strategy. The current targets are short term and short focused.An essential component of “staying well” is to be able to self manage. A target around people with long term conditions accessing self management skills enhancement is needed.The targets for this strategy are not clear and this is a shortcoming.  |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| **280** | Submitter name | Andrew Leslie |
| Submitter organisation | New Zealand Recreation Association |

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| This submission was completed by: *(name)* | Andrew Leslie |
| Address: *(street/box number)* | PO Box 11132, Manners Street |
|  *(town/city)* | Wellington 6142 |
| Email: | andrew@nzrecreation.org.nz |
| Organisation (if applicable): | New Zealand Recreation Association (NZRA) |
| Position (if applicable): | Chief Executive |

Are you submitting this *(tick one box only in this section)*:

[ ]  as an individual or individuals (not on behalf of an organisation)

[x]  on behalf of a group or organisation(s)

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission, and your name(s) will not be listed in the published summary of submissions, if you check the following box:

[ ]  I do not give permission for my personal details to be released.

(The above information will be taken into consideration if your submission is requested under the Official Information Act 1982.)

Please indicate which sector(s) your submission represents
*(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

[x]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

[ ]  Professional association

[ ]  Academic/research [ ]  Other *(please specify)*:

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| Obesity, mental health issues and diabetes are mentioned in the New Zealand Health Strategy consultation draft as some of the most serious challenges our health system is facing. Connecting families, individuals and communities with opportunities to improve their health through recreation is part of the solution, and should be mentioned specifically and reinforced as a key plank in this Strategy, especially given its stated strategic themes and principles.At our recent National Conference, the Honourable Dr Jonathan Coleman, Minister of Health and Minister for Sport and Recreation, spoke with great clarity and enthusiasm about the importance of recreation in obtaining positive health outcomes. As a government priority it would make sense for the role recreation plays in healthier communities and better health outcomes to be recognised in this Strategy.There are massive health benefits that arise from recreation, and there is a growing body of research showing a strong correlation between recreation and not only physical, but also mental wellbeing. Contact with nature through outdoor recreation, for example, is being shown to reduce stress and lessen the impact of mental health conditions. This is supported by studies including The Department of Conservation’s excellent summary study [*Health and wellbeing benefits of conservation in New Zealand*](http://doc.govt.nz/Documents/science-and-technical/sfc321entire.pdf), which concluded that (amongst other things) “Green spaces seem to influence health and wellbeing in three main ways: by providing opportunities to partake in physical activity; by facilitating the development of social capital; and through direct restorative effects, including recovery from stress and ‘mental recharging’” (p.27).[*The Costs of Inactivity*](http://www.aucklandcouncil.govt.nz/EN/planspoliciesprojects/reports/technicalpublications/Documents/costsofphysicalinactivityreport.pdf), a 2010 study into the economic impact of inactivity, estimated that 246 premature deaths per year could be attributed to a lack of physical activity. It also estimated the cost of inactivity to the economy at $1.3 billion per year, of which $614 million was direct (consisting of actual health expenditure and health promotion costs) and the remainder was indirect, including monetary values for loss of productivity, pain and suffering.This suggests there is a significant opportunity to save money in the long run, including on health and wellbeing, by increasing investment in recreation programmes, facilities and linkages with the health sector. This should be acknowledged and clearly stated in the Strategy.Although there is peripheral mention of interaction with NGOs and prospective partners, and specific mention of harmful conditions such as diabetes and obesity, there is no specific mention of the value of helping New Zealanders to lead less sedentary lifestyles. This may be implied in the Strategy, but the subject is not approached directly.The desire to take part in recreation for physical and mental health to connect with new people and to learn new skills is almost universal in New Zealand. In the Sport New Zealand *Active NZ Survey 2013/14*, 90.7 per cent of New Zealand adults stated “Fitness and health” as their main reason for participation, followed by enjoyment and social reasons.New Zealand is among the most active nations in the world. More than nine out of 10 (94 per cent) of adults participate in recreation or sport each year, and two thirds (66 per cent) say they would like to try a new recreation activity or do more of an existing one.We are also among the most obese nations in the world, and the third most obese nation in the OECD (Ministry of Health, *Understanding Excess Body Weight*, 2015). There is a paradox here, and a clear void between those who are active and those who are not.People love recreation, however many providers are ‘speaking to the converted’, and there is an opportunity for recreation providers to work more closely with health providers, including DHB’s to ensure those that would benefit the most from recreation have access to appropriate programmes that would help to foster a healthier lifestyle long-term.  Physical activity keeps people healthy in body and mind and arrests a wide range of ailments. It is widely recognised that New Zealand has an aging population and recreation can play a vital role in slowing the aging process by keeping people active. It is imperative that the Strategy recognises that investment in recreation and physical activity has a direct impact on reducing numbers requiring secondary care in an aging population, and therefore the future impact on the health system.Partnership with recreation providers will result in healthier people, connected communities and a strong economy. The connection between health and recreation must be stronger, and a great way to achieve this is for the health industry to make sure those who would most benefit from recreation have clearer pathways to access these opportunities.Examples of great initiatives are already in play, from partnerships between pharmacies and sports trusts such as the Kaiti Hill Challenge to the Ministry of Health’s own programmes, such as Healthy Families New Zealand and Green Prescription.The importance of programmes such as Green Prescription and Healthy Families must be raised in importance, and we believe greater emphasis on the proven success of these programmes needs to be highlighted. These are programmes that address the needs of those most at risk. Both programmes continue to produce excellent outcomes but are grossly underfunded across the country and tend to be at the funding whim of DHBs who vary in the priority they give to these programmes resulting in disjointed delivery methods and how GRx and Healthy Families are applied.We see these initiatives as the lifeblood of a new, collaborative approach, creating links across society that provide broader support and establish healthier lifestyles for communities and individuals. The pathways that can be taken to increase participation or utilise recreation, either as a preventative measure or as a form of treatment must be mentioned specifically and emphasised in this Strategy rather than underplayed. NZRA is keen to work with Ministry of Health to improve outcomes, facilitate connections and offer support as needed. |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| NZRA applauds the intent of this statement. It emphasises a holistic approach to health, and one that should presumably incorporate physical activity and greater links between the health and recreation sectors.As a result, we propose that more emphasis be placed on the opportunities provided by greater links between health and recreation. We also request an amendment to the wording of the statement capturing the future we want for our health system, along the lines of “…in a smart system that connects with relevant partners”. |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| We agree that these eight principles capture the essence of a fantastic direction for the health system in New Zealand, and see great potential to work with the health system in implementing principles one, two, three, seven and eight.These principles capture the essence of what is required to achieve the Statement of future direction, and we commend the Ministry on the addition of principle eight, which provides a much broader context for how we can achieve a healthier society, as well as potential for better relationships and partnerships.We are happy to work with the Ministry of Health to create the valuable outcomes that these principles lead to. |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| This is the area we feel needs a more specific focus on the relationship between physical activity and good health. Given the stated intent of this Strategy, and its laudable guiding principles, we were surprised to see very few links made between good health and physical activity. Although there was a mention of recreation in a graphic illustration on page three and there may be some indirect implication in other places, there were no direct mentions of the benefits of recreation for both physical and mental health in the body text of the document.As an example, strong links are mentioned in relation to “housing, social development and corrections” on page 17, but no links are drawn to agencies or initiatives that provide community recreation opportunities. We request this paragraph is amended to include recreation providers. |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| The themes and actions described cover digital technologies and the provision of information, which are passive rather than active ways of helping people overcome the challenges of poor health.We request the following wording changes as examples of where wording could be further specified:* Theme 2 Action 5h be amended to state “healthier choices, including recreation opportunities, easier for all New Zealanders.”
* Theme 2 Action 6 include steps to encourage physical activity for children and young people.
* The Ministry consider what steps in this strategy can connect people with relevant recreation opportunities.

 * Action 10 to be amended to mention “…funding for longer-term care including recreation opportunities”.

We hope revisions will not be limited to these changes.In addition to the changes above, for the recreation industry to be involved and delivering to health industry audiences it needs to be appropriately funded, whether the funding is distributed to existing initiatives, new projects or partnerships between industries or sectors.As mentioned in [*The Cost of Inactivity*](http://www.aucklandcouncil.govt.nz/EN/planspoliciesprojects/reports/technicalpublications/Documents/costsofphysicalinactivityreport.pdf), positive outcomes can be achieved when money is invested in better recreation opportunities. When compared to overall health budget, government investment in recreation is minimal. This is short-sighted, as, once established, successful recreation spaces and programmes can serve New Zealanders for generations.Investment in recreation should not be limited to programmes. Dollars spent on the built environment, such as cycleways and walkways, can save considerable costs in healthcare in years to come.More investment in opportunities for people to get active is needed, and this cannot be achieved while working in silos. Investment in recreation is an investment in the long-term health of the community, and the Strategy should acknowledge this and promote the value of increased investment. |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| Organisations across New Zealand, including recreation providers, are willing to engage with the Ministry of Health to improve the health of New Zealanders. For many, improving physical and mental health is one of their primary goals. The Ministry needs to not only engage proactively and directly, but also create opportunities for interested partners to engage on their own terms in ways that will support and align with the intent of the New Zealand Health Strategy.Establishing clearer points of contact and referral between industries such as healthcare and recreation will form stronger links between these industries for the benefit of New Zealanders. Much of the Strategy and Roadmap mentions ‘providing information’ as a course of action and output, however this is only part of the solution and should not be considered an end point. If clearer pathways are established for individuals, as a result of better links between core health services and those offering recreation opportunities or rehabilitation services, this will lead to a more connected health service that is better aware of, and better able to provide meaningful solutions to heath issues.A roadmap that empowers health providers to refer patients to a recreation provider for a specific sort of exercise as a solution to a condition, or a preventative measure, will provide healthcare that will last throughout people’s lives. GPs and GP practices have a key role to play in streamlining pathways to physical activity and recreation as part of medical treatment. However they need to be resourced to do this.GP and practices are time poor and under pressure. To be effective they require additional support and personnel with the time to provide treatment plans and options beyond simply prescribing a pill or dealing with what is in front of them. In essence, they should be enabled to deal with the root cause rather than looking simply to treat the symptom being presented.The Primary Health Organisations (PHOs) also have a role to play. Any tendency to use funding to grow their own internal resource rather than invest in community providers who can effect change should be avoided. PHOs need to be encouraged to direct or redirect funding support into preventative physical activity and recreation services that can impact positively on obesity, cardiovascular disease, cancer, respiratory, diabetes, orthopaedic and mental illnesses.For example, programmes like Green Prescription have the potential to achieve direct results through the prescription of physical activity as opposed to medication. At present, this programme has been given limited scope, however it has great potential.If the channels from health provider to recreation provider are clearer and more established, this will lead to more comprehensive long-term support for people suffering from chronic conditions, who become aware of how lifestyle choices influence their health from experience rather than information, as well as more efficient referral to treatment providers such as physiotherapists when people do have a manageable health issue.One measure of the Strategy’s success may explore direct referrals through partnerships as a less passive solution – and this may well be a two-way street with cases where data can be recorded on both sides of the partnership. This approach can see people more adequately supported after interactions with the health system, with broader support to cope with and potentially overcome their conditions, as well as better prevention for those who may be likely to develop these conditions.The Roadmap also does not mention creation of programmes in partnership with other organisations. We suggest this could be a priority, as it is through tailored programmes and joint funding that a truly ‘people powered’ system can be achieved. A measure for this could explore the creation of joint prevention and rehabilitation programmes. Another outcome measure that could be incorporated may explore the number of partnerships established with different recreation providers over X number of months or years.Another aspect that seems to be underplayed in the Roadmap is the critical role schools can play. Schools are increasingly the focal point of communities and the hub around which a whole of community approach can be developed. Schools are the ideal locality for the concept of community-based nurses or health teams that can work across clusters of schools in an area addressing nutrition, health and welfare as part of the curriculum with the pupils, working with at risk children and their families linking in with other agencies, inclusive of promoting physical activity. We believe that huge gains would be made with this approach. It would develop generations of children and young adults who would have an understanding of the benefits of physical activity in developing and maintaining a healthy lifestyle. It would instil a major culture/attitudinal shift. |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| We request that the strategy more specifically acknowledges and articulates the role of recreation and physical activity in the health and wellbeing of New Zealanders.We see a lot of potential in this strategy, but without a clearer direction to create strong links and engage other organisations and partners across the board, there is also risk that the aspirations of this strategy will be passed over in favour of ‘business as usual’. Community recreation is traditionally used to increase participation in communities with low levels of participation. We see great possibilities for community recreation as a major plank in this strategy.New Zealand community development practitioners define community development as “...empowering communities to participate towards the building of a strong community, a healthy community, a safe community and a community that is truly reflective of the diversity of people that live within it.”We define community recreation as “A process by which communities identify their own recreation issues, interests and needs and are actively involved in developing outcomes and taking action in ways that support their wellbeing and celebrate their identity.” (NZRA, *Developing Community Recreation Strategy*, 2008)Health and wellbeing is one of the major goals of community recreation. Understanding and empowering our communities to live healthy, active lifestyles through the right recreation opportunities is one of the goals we strive towards, and we encourage others to do the same.We hope the Ministry of Health will recognise the vital importance of seeking out and working with organisations such as NZRA that have experience in concerted community engagement, and hold the keys to engaging with communities across New Zealand.The other side of the coin must, of course, be addressed; that of the impact of fast foods, unhealthy foods and sugary beverages. To address the growing health issues that are facing New Zealand there needs to be concentrated promotion of the negative effects of poor health outcomes associated with consumption of fast food and sugary beverages inclusive of alcohol. The Strategy must concurrently address the nutritional aspects of good health (e.g. what we are eating and the portions along with potentially regulating additives in food such as sugar, syrups and salts) and take a harder line rather than the current ‘hands off’ approach.Thank you for the opportunity to provide feedback on this Strategy. Supporting resources: 1. *The Costs of Inactivity* <http://www.aucklandcouncil.govt.nz/EN/planspoliciesprojects/reports/technicalpublications/Documents/costsofphysicalinactivityreport.pdf>2. *Sport and Active Recreation in the Lives of New Zealand Adults - 2013/14 Active New Zealand Survey Results*<http://www.srknowledge.org.nz/research-completed/sport-and-active-recreation-in-the-lives-of-new-zealand-adults-2/>3. *The Economic Value of Sport and Recreation to New Zealand*<http://www.sportnz.org.nz/managing-sport/research/economic-value-of-sport-and-outdoor-recreation-to-new-zealand-report>4. *Health and wellbeing benefits of conservation in New Zealand*http://doc.govt.nz/Documents/science-and-technical/sfc321entire.pdf |

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| **281** | Submitter name | Ravi Vas Vohora |
| Submitter organisation |  |

**Ravi Vas Vohora**

BSc Pharm Honours (Strathclyde), Post Box 12022, Maori Hill Post Centre, Dunedin 9043

 MRPharmS (GB), MRSNZ 03 4640182, vohora@xtra.co.nz

4 December 2015

This submission was completed by Ravi Vas Vohora, 579 Highgate, Maori Hill, Dunedin 9010 (vohora@xtra.co.nz).

I make this submission as a private citizen. I permit my personal details to be included in the published summary.

My submission represents the views of a private citizen. My submission follows the order for written feedback recommended by the Ministry of Health (the Ministry). The following statement made as a prelude to my feedback may prove of help to the Ministry to better place in context some of my comments and remarks in my submission.

As a private citizen my feedback is informed by the notion of constitutionalism which serves as the unwritten constitution of New Zealand, as admirably elucidated by the distinguished legal theorist, Albert Venn Dicey. In brief, and, according to my interpretation of Dicey, each one citizen, alongside the duty and liberty to act as an agent for oneself, has the duty and liberty to act as an agent for the rest of us (i.e. for all citizens; for the ‘all of us’).

It is clear that the intent of the Ministry call for feedback is to develop a health strategy for all citizens. A whole of government approach is desired. Please regard my submission as a duty that I perform as an agent for the all of us.

In responding to the consultation questions posed by the Ministry, I would inform that I intend to comment further, in public, on a number of specific topics. Copies of my comments will be available to the Ministry.

In addition to the above statement on my conception of my duties as a citizen, I emphasise the following priorities. Besides their inherent value, these priorities give a suitable backdrop to my response to the consultation questions.

1. Diagnostic accuracy has to be regarded as the essential problem confronting the health services and I would request that the Ministry notes this. The Canadian physician William Osler is rightly regarded as the father of modern medicine. The method of the physical examination is his legacy to medicine and to humankind. For about 100 years now, the medical profession has not been able to improve much on the diagnostic accuracy of the physical examination. It could be that there is not much scope for improvement. Past changes in the health services however have detracted from the value of the physical examination, much to the frustration of the medical profession. This topic needs a more detailed discussion in a separate document which I can provide.
2. Form has to follow function. This observation follows directly from my earlier observation on the inimical effects of past health service reorganizations on the diagnostic accuracy of the physical examination. There is a need to rectify our past mistakes and the current review of the health strategy provides a good opportunity.
3. It would be helpful to institute collection of statistical information to provide an indication of the cost of illness. The cost of illness should prove to be a useful gauge for policy and budgetary purposes. My past interest in health economics could prove useful. As an act of public duty I shall prepare a document and make it available.
4. The current strategy emphasizes shifting health services to become closer to home. Emphasis is also placed on greater team work. Besides an indicator for the cost of illness, there is a need for a better public understanding of Baumol cost-effects. There are policy and operational implications. I can provide further information.
5. The wider social, philosophical, historical, economic, and historical literature contains gems which need notice and I shall summarize these for the public and for the policy-makers well before the release of the final strategy.

I now turn my attention to the consultation questions. I have used the same numbers as used by the Ministry.

I provide my feedback in a summary manner. I am willing to elaborate further on any of my answers, as needed.

**Challenges and opportunities**

1. Worldwide including in New Zealand, non-prescription medicines are the most prevalent mode of treatment of illness. There is considerable scope for improvements which should receive consideration in the health strategy.

**The future we want**

1. Your statement is a very good strap line and consistent with the objectives. I can explain more, if needed.
2. No objection can be taken to the stated principles which could be revised after review of all submissions.

**Five strategic themes**

1. The five themes are suitable as a starting point. The 10-year vision serves as the ‘horizon’ where, after William Blake, “we’ll be able to touch the sky with our little finger”. Useful that these themes are as ‘the rhetoric of imagination’ we need to constantly keep in mind ‘the grammar of hard facts’. I would suggest an annual review, and ‘change of pace and direction’ as appropriate. It is so wise to remain flexible and ‘tethered to reality’.

**Roadmap of Actions**

1. There is beauty in Action 4 “enable all people working in the health system to add the greatest value by providing the right care at the earliest time, fully utilizing their skill and training”. I believe this one action can serve as a roadmap for all the five themes. This action is overarching. The other actions are mere triflings.

**Turning strategy into action**

1. I would emphasize the value of the priorities I described earlier in this document.

**Any other matters**

1. We need to guard against the ‘Willie Sutton rules’. As you know, Willie Sutton was the famous bank robber who when caught at last was asked in court why he robbed banks. The memorable answer was “because that’s where the money is”. It would be a pity if the explanation for the services our patients receive became “because that’s where the funding is”. There is also a need to remain cautious of ‘latest advance’ and ‘vanity project’ peddlers, wishing to lumber the health service with ‘an entire wardrobe of new clothes for the emperor’. I raise these matters with you not for the sake of merriment and diversion. Besides the health strategy, the Ministry is presently undertaking a review of pharmacy because ‘pharmacists are as an underutilized resource’. A Department of Education review in 1988 had recommended changes to pharmacy education because ‘pharmacists are an underutilized resource’. Clearly progress in pharmacy has not been very impressive compared to the following. In the 1960s it took less than 10 years to ‘send men to the moon and bring them back safe’. From the 1980s to now, there has been impressive progress in computing and information technology, in telephony, in the biological sciences including the mapping of the genome. There has been progress across the board in most other areas of science. It needs to be asked why pharmacy made so little progress. I shall be providing the answer to the public, as a matter of public duty. Additionally, there are useful lessons from the pharmacy experience for the entire health system. I wish others to avoid the fate of pharmacy.

The concepts of ‘economies of scale’ and ‘economies of scope’ are reasonably well understood, including in the health sector. The concept of ‘economies of stage’ might not be widely understood. I shall address the gap.

There is a clear link between life expectancy and (a) education, and, (b) income. I can contribute to a better public appreciation of the links, to advance the all of government approach wished in the health strategy.

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| **282** | Submitter name | Dr Pauline Boyles |
| Submitter organisation | Service Integration and Development UnitWairarapa, Hutt Valley and Capital Coast DHB |

**Submission form**

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| --- | --- |
| This submission was completed by: *(name)* | Dr Pauline Boyles |
| Address: *(street/box number)* |  |
|  *(town/city)* |       |
| Email: |  |
| Organisation (if applicable): | Service Integration and Development UnitWairarapa, Hutt Valley and Capital Coast DHB |
| Position (if applicable): | Senior Disability Advisor  |

Are you submitting this *(tick one box only in this section)*:

[ ]  as an individual or individuals (not on behalf of an organisation nor in a professional capacity)

[ ]  on behalf of a group or organisation(s)

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission, and your name(s) will not be listed in the published summary of submissions, if you check the following box:

[ ]  I do not give permission for my personal details to be released.

*(The above information will be taken into consideration if your submission is requested under the Official Information Act 1982.)*

Please indicate which sector(s) your submission represents
*(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

[ ]  Professional association

[ ]  Academic/research [ ]  Other *(please specify)*: **People with disabilities**

**Combined Submission on the Consultation Draft Update of the New Zealand Health Strategy ‘All New Zealanders live well, stay well, get well’ by Sub Regional Disability Advisory Group and the Capital Support Consumer Advisory Group**

**4 December 2015**

*Our submission comes from our personal experience of disability, and from a disability rights perspective. It is influenced by our inclusion in our Human Rights Act 1993, and commitment to the New Zealand Disability Strategy 2001, to be updated next year, and the UN Convention on the Rights of Persons with Disabilities, which New Zealand signed in 2006 and ratified in 2008.*

**Capital Support Consumer Advisory Group and the Sub Regional Disability Advisory Group**

We are making a joint submission on behalf of the two disability consumer groups:

*The Sub Regional Disability Advisory Group (SRDAG*) was established two years ago, includes disabled and family representatives from localities such as Kapiti and Wairarapa and older and younger people, and population groups such as Maori and Pacific disabled people living in the Capital Coast, Hutt and Wairarapa District Health Boards sub region. It takes a community consultative and strategic approach to its work.

*The Capital Support Consumer Advisory Group* includes representatives of a range of disabled people and their families living in the Wellington area who are supported by disability support services funded by the Ministry of Health. Capital Support is a needs assessment and service coordination organisation that gets to hear about the many issues its consumers face, including health issues and frustrations.

The SRDAG and Capital Support are both committed to making health and disability support services in the region accessible and disability responsive, and to having disabled people and their families engage or participate in decisions made which affect them. This approach needs to be adopted by other areas around New Zealand.

## Consultation questions

These questions might help you to focus your submission and provide an option to guide your written feedback. They relate to both parts of the Strategy: I. Future Direction and II. Roadmap of Actions.

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

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| **To ensure health outcomes for people of all ages who experience disability improve inclusion must be present to recognise the disability support needs of all.** Reference to older people, people with chronic conditions and Māori and Pacific and other ethnic groups and children and whanau that provide challenges, to be extended to include disabled people and their families/ whanau. By disabled people we refer to those with long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with othersThe New Zealand Disability Survey’s definition of disability is broadly inclusive (older people and /or those with chronic conditions often have disabilities coming under this definition, as do many Maori and Pacific people, and children. New Zealand ratified the Convention on the Rights of People with Disabilities in 2008. Article 25 includes **the right of persons with disabilities to attain the highest standard of health care without discrimination.** This has not been recognised in the Health Strategy.In 2015 New Zealand signed the UN Sustainable Development Goals. Goal 3: Good Health and Well-being includes *3.8 Universal health coverage.* World Report on Disability WHO/WB 2011 states that overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers (including systemic barriers). **People with disabilities have the same health needs as non-disabled people** – for immunization, cancer screening etc. They also may experience a narrower margin of health, both because of poverty and social exclusion, and also because they may be vulnerable to secondary conditions, such as pressure sores or urinary tract infections. Evidence suggests that people with disabilities face barriers in accessing the health and rehabilitation services they need in many settings.**Making all health care services accessible to people with disabilities is achievable and will reduce unacceptable health disparities.** A commitment to adopting reasonable accommodation principles will advance health services considerably. The Intellectual Disability report findings will show similar trends across other impairment groups – to date research has not been conducted with other groups. The Convention Coalition Monitoring Report 2015 highlighted health access by people with disabilities in New Zealand is a priority issue: **‘*Health*** *22. Some interviewees suggested that the health system is designed for the needs of able-bodied people, and isn’t flexible enough to support the full participation of people with disabilities. Communication issues with health professionals were reported. Mostly, these involved situations where the health professional was not seen to fully respect the person, or didn’t believe that the disabled person could make decisions about what was best for them’.*   |

1. Are there any additional or different challenges or opportunities that should be part the background for the Strategy?

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

**2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?**

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

**3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?**

‘All’ being young, old, from all ethnic groups and location yet does not recognise that ‘all’ also includes the 24% of New Zealanders with an impairment and or with a chronic health conditions (NZ Disability Survey). We as a community live in a disabling society and are also young, old, from all ethnic groups and locations.

Missing is accessibility; recommend**: ‘Providing ACCESSIBLE services closer to home’** to ensure we can also access serviceswith ease like others.

This is a very health-centric statement with good elements. The earlier version had ‘health *and disability* system’.

Critical is the need to ensure the rights of the child and adults with a disability is paramount. This includes recognising their inherent dignity, individual autonomy and the freedom to make their own choices.

Promoting the role of health services to ensure people are able to participate and be included in our diverse society is essential within a strategy. This means not experiencing discrimination or barriers. Living with an impairment or a chronic health condition does not encompass who the person is.

**An investment to accelerate disability-inclusive development and CRPD ratification and implementation of programmes to eliminate the barriers for those with impairments or long term chronic health conditions will make services more accessible and affordable leading to greater efficiencies across multiple ethnic groups, age groups and geographical locations**.

This will take place via reforming policies, addressing barriers to service delivery, human resource barriers and filling gaps in data and research. Educational programmes and messages need to be accessible to all New Zealanders in a manner so they are understood.

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| **One new guiding principle is required: a commitment to the implementation of the NZ Disability Strategy and the principles of the UN convention on the Rights of Persons with Disabilities so New Zealanders with impairments experience equitable health outcomes.**The remaining principles will be useful as guiding principles once there is a document sitting alongside it to demonstrate how each principle can be articulated to ensure those with long term health conditions and those with impairments can also benefit during the implementation phase. |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

**4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?**

* **People powered**: the focus on people power, people drive and people directed while participating in decision making and controlling their own health and wellbeing, and making informed choices with the right information etc., **is supported**. Adopting Supported Decision Making processes is critical for the success of this theme.
* Reference to adapting services and funding approaches which is highly desirable. Need evidence of commitment from the top, and a paradigm shift, to achieve this and investment is required. Introducing Individualised Funding and the Enabling Good Lives approach is part of the process. Particular attention needs to be made to the experiences of those with multiple conditions/impairments.
* Would like to see the concept of **reasonable accommodation** included to improve accessibility of health care for people with disabilities. People with disabilities are frequent users of health services and can readily assist to **eliminate barriers experienced leading to improved performances in overall measures within health system.**
* Our experience in the Sub Regional Advisory Group in Wellington demonstrates the positive outcomes achieved through the Disability Advisory Group as it engages with service users with disabilities and the Executive Managers and Board members of the respective DHBs. The model adopted here is unique.
* The diminishing profile of Disability Advisory Groups across many DHBs is of concern.
* **Closer to home**, e.g. integrated health centres is supported. Yet these services will have little experience with people with very specialised accommodations. World Health Organisation promote the use of a twin track approach where primary services adapt their practice and work alongside specialised networks and NGOs to be effective. This can be achieved through e-technology.
* Community health services are usually good at supporting people in the community, but often seem slightly forgotten services. They also have some policies and processes need modifying e.g. a district nurse will not give a time when she will visit, so a person has to stay home all morning waiting, or go to the clinic at a set time.
* References are made to integrated services for Māori and Pacific communities. Would like to see evidence of a commitment towards integrated health services for those with disabilities also.
* Accessible transport is raised frequently as a vital component to have in place in order to access health services including local services.
* **Value and high performance** – we support a focus on outcomes. We want to see indicators identified that are relevant for people with disabilities and long term chronic conditions.
* We particularly support the reference on p. 18 to the fact **NZ’s health system needs to do better for population such as Māori and Pacific and people with disabilities and to do this we need to remove the infra-structural, financial and physical barriers that exist within the health sector in particular, and across other sectors.** To this we add **attitudinal barriers** also and recommend an investment to bring about a social change in the way staff work with our community.
* Reforms need to take place though a co-design process with people with disabilities including those with diverse disabilities. **Addressing the need to improve access for people with disabilities means all three aspects of the NZ Triple Aim framework will be advanced.** So far CCDHB together with Hutt DHB and the Wairarapapa DHB have succeeded in doing this with the Health Passport, Disability Icon and the development of their Disability Responsiveness programme. The high level of input from disabled people themselves means there is a higher level of trust and confidence in the success of the programme as it is relevant.
* **One Team** We support the concept of reduced fragmentation. Disabled people with expertise should be recognised as full partners in this scheme. While the system is fragmented the concept of a navigator is helpful however the long term approach should be to simplify the system and put the resources into effective services.
* To be effective **leadership from disabled people must also be welcomed** and seen as an integral part of the provision of a responsive team. Research based around effective services for disabled people and those with long term health conditions needs considerable investment to inform positive decision making and team work.
* A commitment towards disability related research over the coming 10 years is required.
* One underestimated role of health services for people with disabilities and long term chronic health issues is the role it has in **ensuring we remain productive as citizens of New Zealand**. When we experience delays or barriers in accessing health services (including dentistry, equipment etc.) it negatively impacts our ability to maintain our jobs and our ability to be productive.
* Within the Health Strategy we need to see statements or references illustrating a commitment to integrate accessibility to all services. This is not evidence in projects as it usually occurs as an afterthought.
* Agree use of technology is critical.
* **Smart system**: Electronic records and portals will have an important use, but any move to good things like better access to information and shared care plans for people with complex long-term conditions need to ensure that all information is accessible to everyone, e.g. blind people, people with learning disabilities and other groups such as the Deaf community could be more disadvantaged unless appropriate adaptations are incorporated.
* Information is also vital for the staff within the service, in our region the disability icon on records assists staff members us knowing how to communicate or work with the individual with an impairment thus reducing confusion, frustration and embarrassment.

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

**5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?**

 The actions listed are weak in showing how health and disability strategies will be integrated more. The actions do not show how the required shift will be made to address the environmental (systemic) and social barriers currently experienced by those with long term chronic health conditions and impairments.

**People Powered**:

***Action One:***

* Need to ensure all information and feedback forms are **accessible to disabled people**.
* Inform and involve people, make sure **all** people take part and benefit.
* Expand the reference to multiple cultures and ethnicities to show people with chronic health conditions and impairments are included.
* Consider use of the National Telehealth Service to benefit PHOs when working with low incidence groups.

***Action Two:***

* Accessibility, service design needs to also reflect universal design principles/reasonable accommodation and include disabled people from the beginning

**Closer to home:**

***Action Three***

* Reasonable accommodation
* (See comments above) While it will be good if disabled people have access to the full range of services closer to home, current mainstream services will need to change considerably to do this. Until then, those e.g. parents of disabled children, will want to retain some specialist services.

***Action Four***

* Disability responsiveness essential part of ensuring people working in the health system are responsive to the people they work with

***Action Five***

* Those with long-term chronic conditions (action 5) are an important group, the health of other groups of people with disabilities also need a focus and attention, e.g. there should at least be support here for the initiative to improve the health of people with intellectual disabilities which has already started**,** as a precursor to improving the health of other people with disabilities.
* Educational programmes must be accessible and meaningful (understood) for all communities

***Action 6***

* Life course approaches need to accommodate the alternative life course taken by individuals with disabilities and chronic health conditions
* We support collaboration on children, families and whanau, providing the collaboration fully includes disabled children and their families.
* Accessibility of information and services is critical for effectiveness.

**Value and high performance**

* The reference on page 18 on recognising the need to remove barriers for Māori and Pacific populations and people with disabilities but this is not reflected in the actions. There is no evidence that people with expertise ie. Those with disabilities will be included.
* Critical to remember low incidence high needs groups
* **An investment to accelerate disability-inclusive development and CRPD ratification and implementation of programmes to eliminate the barriers for those with impairments or long term chronic health conditions will make services more accessible and affordable leading to greater efficiencies across multiple ethnic groups, age groups and geographical locations is critical**
* User surveys need to be accessible for disabled people to use
* Data collected must be relevant and meaningful and show correlations between communities

**One team**

* Need to see a commitment to the implementation of the Disability Convention.

### Turning strategy into action

**6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?**

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| There needs to be genuine engagement with disabled people, and their families and whanau, they need to have genuine input into the development of measures, monitoring and evaluation systems at different levels and different places, and be represented at any steering group level. Active co-design processes must include disabled people.  |

### Any other matters

**7 Are there any other comments you want to make as part of your submission?**

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| We thank you for the opportunity to comment. The document is difficult for many disabled people and older people to access and we are aware the feedback rate from significant disabled leaders is low with reasons given as ‘will we be heard?’ We’d like to think you will ‘hear’ this submission and willingly will engage with you through the process. |

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| **283** | Submitter name | [redacted] |
| Submitter organisation | Quality Improvement Group For Maori Oral Health Providers  |

**SUBMISSION FROM QUALITY IMPROVEMENT GROUP FOR MAORI ORAL HEALTH PROVIDERS**

“UPDATE OF THE NEW ZEALAND HEALTH STRATEGY: ALL NEW ZEALANDERS LIVE WELL, STAY WELL, GET WELL”

Contact person: [redacted]

Chair- Quality Improvement Group for Maori Oral Health Providers

[redacted]

**Introduction**

Thank you for this opportunity to provide feedback on the updated New Zealand Health Strategy (‘the Strategy’).

The Quality Improvement Group for Maori Oral Health Providers (QIG) is a group comprising clinical and service manager representation from the Maori oral health provider sector. Our sector are experts in the provision of primary care oral health services in high health need, high deprivation areas. The QIG provides strategic advice and direction on clinical quality, primary care oral health service provision, and priority areas to address oral health disparities, and improve Māori oral health status.

**Overall comments**

The QIG supports updating the Strategy. The themes and principles of the Strategy provide a platform to build on health system strengths, identify areas for improvement, and create an opportunity for an improved culture of collaboration across the sectors where everyone in their respective areas has a responsibility to contribute to good health and well-being of our people.

But the QIG is concerned that the realisation of the Strategy as it relates to oral health is unattainable and unachievable if inequities in the oral health system are not prioritised or addressed. The themes (people powered, closer to home, value and high performance, one team, and smart system) will have little meaning if necessary changes are not made to the way the oral health system is organised and delivered, especially for low income adults and those with chronic conditions or at risk of poor health.

The current oral health system for low income adults and people receiving welfare assistance is built around ‘emergency’ dental care. Both the Ministry of Health (via district health boards), and Ministry of Social Development (via Work and Income New Zealand), provisions for emergency dental care are inequitable, inadequate, and economically inefficient. We know that cost is a significant access barrier for people on low incomes and with high health needs (MoH, 2009; Jatrana et al, 2009; Robson et al, 2011, MoH, 2013), and Maori feature disproportionately in both categories. We also know that the current model of hospital based dental care is expensive and the demand is increasing (NZOHCLNG, 2012). Despite significant investment in the reconfiguration of child and adolescent services, we are concerned that disparities in child oral health for Maori, and Pacific children and adolescents persist (MoH, 2009).

We welcome this opportunity to present our feedback on the Strategy and advice about how further consideration of how oral health could and should be incorporated within it.

**Question 1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?**

Current oral health policy and service provisions for people with chronic conditions and/or low incomes are non-existent or grossly inadequate exacerbating inequities in oral health and oral health outcomes. The effectiveness and efficiency of general medical care will be undermined if the health system fails to invest and provide medically necessary dental care to those at risk of poor health outcomes. The consequences of oral disease are often minimised or discounted yet oral health complications reflect, exacerbate, and may even initiate other oral health problems and they have a profound negative impact on quality of life (Qualis, 2015).

Too much is being spent on expensive dental treatment which could’ve been prevented with lower-cost, lower-risk intervention. The delivery of basic dental treatments (i.e. tooth extractions and restorations, and treatment of acute infection) in hospital based dental clinics is a wasteful use of valuable resources; these services are suited to the primary care setting. In 2009, $39million was spent on hospital based dental treatments alone; and demand for emergency dental care doubled from 2007-2010[[1]](#footnote-1).

Additional challenges include:

* there is a high and disproportionate burden of oral health disease in New Zealand
* oral health disease is epidemic with high social and health costs
* Oral health has been silo-ed out from medical health for far too long
* Prevalence, severity and cost of this mostly preventable disease does not get the attention it deserves
* The current oral health workforce is not responsible for and is not capable of fixing the entire nations oral health problems

Changes and improvements to current oral health policy and service provisions could make a huge health difference to overall population health, and make the system more equitable. Evidence shows there is an inextricable link between good oral health and good general health (MoH, 2009), and people with chronic conditions are at risk of poor oral health. Given oral health disease is mostly preventable, significant opportunities exist to improve access to dental care, and improve the oral health status, particularly of disadvantaged population groups. The lack of focus on preventive dental treatment is also a barrier and contributor of poor oral health status for low income adults and people with chronic conditions. Policy provisions purposefully exclude any work that is non-urgent[[2]](#footnote-2). There must be a focus on **essential** dental care and to include preventive oral health care in routine medical care. Prevention is the very basis of primary health care. The updated Strategy needs an increased emphasis on the prevention of oral health disease and through inter-professional collaboration include basic oral health clinical content and competencies (Qualis, 2015; NMOHCS, 2012; NMOHCS, 2014).

Opportunities include:

* Inter-professional collaboration and making oral health an essential part of primary care
* The inclusion of oral health as a component in PHO Clinical Performance Indicators, and the Care Plus programme for people with or at risk of chronic conditions
* Policy changes to the Special Needs Grant programme[[3]](#footnote-3) for emergency dental care for low income adults to address inequities in access
* Shifting basic dental treatment services at hospital based clinics out to primary care dental providers
* Policy changes that support ‘essential’ rather than ‘emergency’ dental care

**Question 2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?**

The statement needs to reflect a health system that is equitable, and inclusive of the social determinants of health.

**Question 3. Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?**

Suggestions:

Principle 3: collaborative health promotion, *protection*, and disease and injury prevention by all sectors

Principle 6: a high performing, *quality, and responsive* system in which people have confidence

 Principle 8: thinking beyond narrow definitions of health and health care delivery through inter-professional collaboration to achieve well-being

**Question 4. Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?**

Yes, however, if nothing is done to make policy and service changes to the way the oral health system is organised and delivered, then these themes won’t make a difference for improving oral health outcomes and reducing oral health inequalities, and have the real potential to undermine efforts in general health.

**Question 5. Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?**

Action 1: D. New partnerships must include dentistry. Efforts and skills of both primary care providers and dentists are necessary to reduce the burden of oral health, and improve general health outcomes. As part of this new partnership, dentists must have access to patient health information to assess, reduce risk, screen, put in place preventive measures, and identify patients in need of dental care.

Action 2: B. Oral health is an ideal and appropriate health issue to support clinician-led collaborations. Building links with Primary Care was identified as an Action area of the 2006 NZ Oral Health Strategy. The Ministry has failed to address actions outlined in this action area of the strategy. Some of these are:

* Have not developed a policy framework to encourage more explicit links between primary health care and oral health services
* DHBs have not considered the capacity and potential for development of PHOs in their regions (this should not be limited to PHOs; NGOs including Maori oral health providers must be a part of the mix of services)

Action 3: A. Shifting services - opportunities to shift hospital based dental treatment services out to primary care based dentists are not being adequately explored or in some cases withheld by district health boards. The Service Specification allows for primary care dental providers, but the experiences of Maori oral health providers to date are indicative of a protracted and difficult process working with district health boards, despite cost savings, and closer to home advantages. Maori oral health providers with capacity and capability have been unable to secure these services when these are the very patients who are already enrolled with their PHO and Maori provider service. It not only goes against the principles, themes, and actions of this updated Health Strategy and the BSMC strategy, but actually prevents services to deliver a model that supports people to get well and stay well.

Action 5: a new action about oral health and diabetes is needed because:

* About one third of people with diabetes have severe periodontal disease
* Evidence demonstrating relationship between periodontal disease and diabetes
* Among patients with diabetes, periodontal disease appears to accelerate both pancreatic failure and end-organ ischemic vascular disease, including stroke, myocardial infarction, and renal failure
* Oral Health care will help reduce the risk of developing complications for those with diabetes
* Effective diabetes management and good oral health are impossible to attain without self-management skills,
* Inter-professional collaboration between dental and medical health will help reduce the incidence and adverse impact of diabetes on the quality of life of their patients

Action 6: a new action about oral health and tamariki is needed because:

* Dental caries is the one of the most common chronic diseases of childhood
* Oral health disease and infection has a profound negative impact on children’s lives and compromises their learning and healthy development
* ASH and hospitalisation rates show high and disproportionate rates for tamariki being admitted to hospital for dental treatment

Action 8: the framework must include principles of equity

Action 10: A. Legislative provisions and financial support for Low Income Adults accessing dental treatment must be reviewed as part of the Ministry’s advice on the best way to ensure access to services for those who need it most. The provisions for emergency dental care administered by the Ministry of Social Development are inequitable, and inadequate. There has been minimal engagement, discussion, accountability or responsibility from both the Ministries of Health and Social Development to address the problem of emergency dental care for low income adults. Both Ministries must work together to review this programme, and improve provisions for low income people and older people.

Action 11: A,B,C. As part of this work, there must be an expectation on district health boards to work with, and invest in, Maori health providers. This group of NGOs work closely with high need, high deprivation population groups in a mix of settings, and models of care. Maori oral health providers would be an ideal case for investment for developing standards and guidance for the health sector for making oral health an essential component of primary care.

Action 19. Dental expertise must be included in the development, design, and implementation of the national electronic health record, such as patient portals. Despite advances in IT and obvious gains to patient care, medicine and dentistry do not ‘talk to each other’, and have progressed independently of each other. If services are to be integrated people and services need to communicate and exchange information effectively and efficiently, especially when they share in the care of the same patients. Dental information is especially important for managing patients with chronic conditions such as diabetes and cardiovascular disease where access to patients’ dental information could assist with early detection of chronic diseases.

Action 20: A. Oral health plays a vital role in a person’s overall health and well-being. Prioritisation of oral health knowledge in this action is required to:

* Ensure better management of patient care and health outcomes
* Investigate an oral health framework for making oral health an essential component of primary care
* Identify practices that will streamline the patient experience through the health system, so that services themselves do not become barriers

**Question 6. What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?**

Ethnicity must be included as a priority in tracking and reporting progress. But it would be more helpful if there was a cross-analysis to inform trends by ethnicity, gender, deprivation, age group etc.

If we are to understand how the Roadmap of Actions is making a difference, then we must also identify, gather, and share information from and with other sectors, including employment, housing, and income. Consistency and quality of information is also crucial to provide a robust picture of improvements in health status for disadvantaged population groups.

**Question 7. Are there any other comments you want to make as part of your submission?**

Internationally, steady progress is being made to make oral health an essential part of primary care. New Zealand is lagging behind these developments; action is needed to understand the prevalence of oral health disease in primary care, and explore opportunities to include preventive oral health care in routine medical care. Prioritisation of oral health in the NZ Health Strategy is necessary because:

* The WHO policy is that oral health is integral and essential to general health and is a determinant factor for quality of life
* Oral Health is part of the WHO Chronic Disease and Health Promotion programme
* WHO asks countries when initiating or strengthening national oral health programmes to focus on integration of oral health into national and community health programmes
* The closer alignment of oral health with general health creates a significant opportunity for dental health professionals to help reduce the incidence and adverse impact of chronic conditions on the quality of life of their patients

[END]

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| **284** | Submitter name | [redacted] |
| Submitter organisation | Starship Child Health Nursing Clinical Governance Council |

[redacted]

Clinical Nurse Consultant

Starship Child Health Directorate

Private Bag 92024 │ Auckland Mail Centre │ Auckland 1142

[redacted] |[redacted]

Thank you for this opportunity to comment on the update to the New Zealand Health Strategy.

This submission has been prepared on behalf of the Starship Child Health Nursing Clinical Governance Council. The Governance Council is a representative group of the Starship Child Health Nursing workforce.

We agree in principle with the suggested strategy and action plans however we do have concerns regarding the ability to successfully achieve the aims if not adequately resourced.

Children and young people are acknowledged throughout the document, however we believe the strategy needs to include them as a central point of focus. Children and young people are our investment in New Zealand’s future, and their health is a vital part of that investment. While much good work is already underway in respect of child health, there are many challenges that remain.

* The vulnerability of children places their well-being at risk to the wider societal changes, challenges and inequalities that affect their parents and caregivers.
* Inequalities exist for children, for example the variance in cost of after-hours medical centres for children is a barrier to good primary care
* Other’s behaviours, attitudes and life-circumstances can impact on our children and young people and threaten their prospects of sustained good health.
* New health issues have emerged in recent years, sometimes as a direct result of the complex interactions between health and society. For example Mental health is a key determinant of health, even in childhood.
* There are increasing numbers of infants and children living longer with disabilities and complex health care needs.

Early intervention during childhood is vital as this will lead to a healthier New Zealand in the future. Interventions such as breakfast in schools, and increased resourcing for services like Plunket, public health nursing and school nurses.

Given the crucial role of other sectors and influences, such as; education, social care, justice, housing, good nutrition and healthy life-styles, environmental improvements and initiatives to address inequality and disadvantage, in delivering improved outcomes for children, a strong emphasis needs to be placed on effective interagency working.

We recommend the appointment of a Minister for Children. This role can take a lead on looking at all legislation including health, education, social policy, housing development, transport improvement, and its impact on children and young people. This role is vital in casting an eye on all legislation changes, both current and future, for children who are vulnerable and invisible in our system.

While we acknowledge and support the aim of People Power, we question the choice of words and suggest Person Centred as an alternative. We acknowledge that we cannot empower people. We can enable people to become empowered but people need to empower themselves. If not everyone is able to be empowered, how then do we ensure that we adequately hear and resource vulnerable populations.

In addition to the position of children and young people in the strategy, we believe the nursing workforce is also largely invisible within the strategy. Nursing is the biggest health workforce and has a large impact on health outcome. There is a large capacity for improvement in health through nursing and particularly through nurses in advanced practice roles. For example, Nurse Practitioners working in a funded primary health care model would further enhance the care to remote and vulnerable populations.

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| **285** | Submitter name | [redacted] |
| Submitter organisation | Te Pou o Te Whakaaro Nui |

4th December 2015

Kia ora,

**Response to New Zealand Health Strategy consultation**

Thank you for the opportunity to provide feedback on this important strategic policy document for the health sector.

The attached response has had input from many people within our organisation, and has promoted much discussion and debate.

We look forward to seeing the final document and working with the Ministry of Health on putting the ‘roadmap’ into practice.

Yours sincerely,

[redacted]

Chief Executive

### Introduction

This submission from Te Pou o Te Whakaaro Nui, in response to the draft update of the New Zealand Health Strategy, uses the submission response template provided by the Ministry of Health. It is structured as suggested in the consultation documents.

Te Pou o Te Whakaaro Nui is pleased to have the opportunity to respond to the draft and participate in the consultation process for this important policy document.

### Challenges and opportunities

1. **Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?**
* We suggest that an additional challenge is that of balancing strong national leadership of the health sector with responsiveness to regional and local need. We are aware of emerging concerns at the lack of consistency around the country in relation to access to and quality of health care services. This has been documented for a number of services, for example Collings et al. (2010)[[4]](#footnote-4) noted the lack of a strategic policy context for primary mental health services, resulting in “substantial variation in focus, approach and equity of access across PHOs, and lack of connection with the wider primary care and DHB services” (Collings et al., 2010, p.25). We note that primary mental health services still have no strategic policy context, although *Rising to the Challenge* identified this as a priority for the Ministry to develop.
* For the health system to address the challenges and be equipped for the future there needs to be careful consideration to workforce re design to ensure that roles are properly designed to meet the needs of people. This could identify the development of new roles or change in scope of roles. An approach that solely focuses on training more of what we have now will not be sufficient for the future
* It appears that the Ministry’s capacity to develop and implement workable policy and clinical guidance for the sector is currently rather uneven across services. While we agree with the principle of empowering individuals and communities to take more responsibility for managing their own health, this should not be done at the expense of strong national policy and monitoring for consistency and quality. People should not receive a completely different quality of health service response depending on which part of New Zealand they live in.
* We note that this section (paragraph 5) identifies that Maori and Pacific people have a lower life expectancy compared with the general population, and that children as a population may not be accessing the health services they need. We suggest that a paragraph on socio-economic factors also be included as a determinant of health outcomes. At present this paragraph reads as though Maori and Pacific ethnicity and childhood are the main determinants of poor health.
* Families living in high-deprivation areas are disadvantaged in many ways and more exposed to risk factors, including being more likely to have poor nutrition and weight problems. We suggest it is unhelpful to single out Pacific children as being more likely to be obese.
* There is no mention of people with mental health, addiction and disabilities problems in this section. These problems affect up to 20 per cent of the population, who have reduced life expectancy and access to physical healthcare services and treatment, are more likely to be living in high-deprivation areas, and whose pharmacological treatment is likely to have a negative physical health impact. This is particularly the case for people with more severe mental health problems.
* It is not clear what countries New Zealand is being compared to in the statement “NZ is unusual in that most health expenditure is funded by taxpayers” (p. 6). We question this claim and request that it be further explained, as it may be central to the solutions that are put forward in the ‘roadmap’ section.
* We support a focus on prevention and “making healthy choices easy”, using good research evidence about factors that contribute to good health throughout the life cycle (p. 7).
* We also support preventative systems-level change, including managing risk factors for disease via evidence-based national and local policy and regulatory mechanisms.

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

1. **Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?**
* The statement is aspirational and consistent with the vision of this organisation.
* We strongly support the second paragraph of this section that states “the important need for this Strategy to reduce disparities in health outcomes, and make sure the health system is fair and responsive to the needs of all people…”

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

**3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?**

We support these principles in full and agree that they will provide helpful guidance for the future.

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

**4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us**

**1. People-powered**

* We support the use of digital technology to provide encouragement for self-management and note that there are several good examples of how this has been utilised, developed in New Zealand over the last ten years, eg apps for smoking cessation, and computer-based self-management of depression (The Journal, SPARX).
* We support the practice of placing individuals in control of resources to support their own health, where this is possible, when this is what they want, and with the support of their families/whanau and communities.
* The examples of ‘what great might look like in 10 years’ looks like good practice right now (ie is probably not a stretch for many health services), with the exception of electronic patient portals in primary care which is not yet widely available. We support this development as it helps to address some of the asymmetry of information that characterises many medical services.
* We would like to see more information about how these kinds of outcomes are going to be measured, at both individual and population levels.
* We suggest that ‘people powered’ ought to include employing and using skilled service user leaders and advisors at all levels of health service delivery, and particularly in mental health, addiction and disabilities services.

**Action 1:** *Improve co-ordination and oversight and expand delivery of information to support self-management of health through a range of digital technologies.*

* We agree that self-management of health ought to be encouraged, and support the role of the health sector in improving health literacy, but have concerns about information for service users being too clinical and using jargon. We support service users being included in developing information in plain language for other service users.
* The role of peer and family support can also be an important component of this approach, and there is promising work being undertaken in mental health which supports including peers and/or families in decision making about the person’s health care. Additional research in this area is necessary to support policy and service development.
* We agree that in theory, digital technologies may be very helpful in supporting individual efforts to improve health. However we caution that the evidence is still very limited for the effectiveness of using these technologies to improve health outcomes. We are aware that some New Zealand research has been undertaken (for example with SPARX) and we support greater investment in well-designed and ongoing evaluation and research in this area.
* We note that the technologies are advancing far more quickly than the research base. We are also aware that there is evidence that the effectiveness of such technologies can be increased with the provision of some level of personalised support, especially in the case of e-therapy interventions for mental health problems.
* There would need to be some monitoring of apps in the market place to ensure they have an appropriate evidence base, and are not going to do people harm.

**Action 2:** *Promote people-led service design by collecting and sharing good examples of it from design laboratories and practices: focus especially on those examples that effectively reach and understand high-need priority populations.*

* We support the development of ‘people-led service design’ and particularly in mental health, addiction and disabilities services, where the people leading should be skilled service leaders who are remunerated appropriately. The concept of ‘people-led design’ should include family and whanau where possible.
* For this to happen we need to build the capability of people who are able to be involved in co-design. We can’t assume that people will know how to do this without building the knowledge and skills in this area. Specific workforce strategies are required for both people working in services as well as those that we are seeking to be involved in co design work, eg Fellowship for young people to be involved in co-design led by Lifehack.
* We strongly support collaborative efforts to engage with high-need priority populations on key health issues, and suggest that Equally Well is a good example of such an approach. However we do not support these being clinician-led only and propose co-design alongside service users as best practice, while also ensuring the input of people with expertise remains a priority.

**2. Closer to home**

* We agree that health starts at home and local service delivery is sensible for many health services, and certainly those that focus on wellness and prevention. We acknowledge that highly specialised services cannot be provided everywhere. The use of technology such as telemedicine and skype can assist with making specialised expertise available to ‘closer to home’ services in more remote localities.
* Well-co-ordinated health and social services are certainly important for long-term health conditions, including mental health problems. There is a need for greater recognition of mental health conditions associated with long-term physical health problems and disabilities.
* To enable the health system to work effectively with other agencies, we need to promote and develop the capability for organisations to develop partnerships and work collaboratively. It will also be important to look at systems for shared measurement so that we can identify how this has been effective.
* People with multiple health conditions need integrated pathways of care, and preferably one care plan.
* We strongly support the publicly funded provision of universal health services for children and young adults, and more investment in this population, including effective early intervention services for mental health conditions, particularly psychosis. Such interventions should include non-pharmacological approaches such as talking therapies, wellness programmes and sensory modulation, as well as medication.
* There is a need to invest more in practice-based research that enables others to learn from innovation and good practice that is meeting the needs of New Zealanders.
* We support in principle the 10-year outcomes identified for this section, but again, suggest that we are lacking information about our current status in relation to these outcomes. Good baseline data is needed to measure the impact of efforts to achieve against the outcomes sought. This is particularly the case for preventative attempts. Regions and localities need good current information about who the communities they support are made up of.

**Action 3:** *To maximise value for people and achieve the best health outcomes, the Ministry of Health, with input from the system, will ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way*

* While we support this statement in principle, it is not clear how the actions outlined will make a difference to what DHBs are already providing, or attempting to provide.
* Community-based approaches will require strategies to build people’s capability.
* Equitable allocation of Vote Health funds using the PBFF is an essential pre-requisite to more consistent quality and access to services around New Zealand.
* We note that epidemiological research is needed to understand population health needs.

**Action 4:** *Enable all people working in the health system to add the greatest value by making sure they are providing the right care at the earliest time while fully utilising their health skills and training.*

* We support the careful removal of legislative barriers to allow pharmacists and nurses to prescribe pharmaceuticals under specified circumstances, and we especially support a strengthened role for nurses in the prevention and management of mental health problems.
* We support the role of telehealth in principle, to improve access to good quality information and advice.
* There will also need to be consideration of curriculum at both undergraduate and postgraduate levels to ensure there is clarity about the right care and the earliest time.
* For people to fully utilise their health skills and training there is a need for action on how people can work to ‘top of scope’. There are a number of barriers to this that are a result of role design and how these work within organisations. Organisations need to consider whether workforce roles are developed to meet the needs of the future. A literature review on this can be found at http://www.tepou.co.nz/resources/scope-it-right-working-to-top-of-scope-literature-review-summary/577.
* A great understanding and acceptance within the health sector of ‘stepped care’ (or ‘layered care’) models across prevention, early intervention, primary care and secondary services is also needed to support this action.
* It may be helpful to house related services together to facilitate more effective collaboration.

**Action 5:** *The Ministry of Health and DHBs will increase the effort on prevention, early intervention, rehabilitation and wellbeing for long-term conditions such as diabetes, cancers, cardiovascular disease, chronic respiratory conditions, mental health conditions, musculoskeletal disorders, and for obesity, addressing common contributors or risk factors of these conditions and focusing efforts on points in the life course with the greatest opportunity for success.*

* We strongly support an increase in efforts on prevention and early intervention, and the inclusion of mental health conditions as a priority in this section on long-term conditions.
* We support a focus on mental health conditions as the initial focus for reorienting planning guidance and performance management, as mental health conditions are strongly associated with all of the physical health problems identified. A recent literature review on this can be found at http://www.tepou.co.nz/resources/the-physical-health-of-people-with-a-serious-mental-illness-andor-addiction-an-evidence-review/515
* We support the addition of service user networks to clinical networks to strengthen collaborative approaches to long term conditions that span DHB boundaries.
* We have concerns about the role of second generation psychotropic medication on obesity, not only amongst those people who have serious mental health problems, but also in relation to ‘off-label’ prescribing within the general population, eg for sleeping problems, and amongst the elderly for managing dementia. We note that recent Pharmac annual reports document a significant (three-fold over the previous ten years) increase in the number of prescriptions for these drugs.
* We support all of the actions identified to address long-term conditions and obesity, and we suggest that tackling obesity will also require strong national leadership and a comprehensive approach similar to that employed in reducing tobacco smoking prevalence. The actions on this list will not be sufficient to make the impact needed as it is silent on the most effective tobacco control measures – ie legislation, regulation, taxation, and monitoring across a range of educational, social welfare, local government and health settings.
* We support the application of the WHO’s principle of “proportionate universalism” ([Marmot et al., 2012](#_ENREF_175)[[5]](#footnote-5)) – to both improve overall population health, and also reduce inequities by attempting to bring the health of everyone up to levels achieved by the most advantaged. Proportionate universalism involves the development of universal policies that are implemented at a level and intensity of action that is proportionate to need.

We support the WHO’s recommendation that governments:

* avoid focusing on the individual attributes and behaviours of those who are socially excluded
* focus on actions across the social gradient in health that are proportionate to need, rather than the gap in health between the most and least disadvantaged groups
* focus actions on releasing capacity within organisations, professional groups and disadvantaged groups to achieve long-term improvements in resilience and on how those who are socially excluded are able to live their lives
* empower disadvantaged groups in their relationships with societal systems ([World Health Organization, 2013, p. 17](#_ENREF_330)[[6]](#footnote-6)).

**Action 6:** *The Ministry of Health will continue to collaborate across government agencies, using social investment and life course approaches, to improve and make more equitable the health and social outcomes for all children, families and whanau, particularly those at risk.*

* We strongly support all of the actions outlined, and particularly increased support for pregnant and postnatal women experiencing mental health and alcohol and other drug conditions, and the promotion of healthy nutrition and activity for these women.

**3. Value and high performance**

* We support all of the dot points under the heading ‘this theme is about’, particularly the need for better information to drive learning and decision-making.
* We suggest that the national KPI benchmarking forum lacks leadership and accountability for under-performing services. It would be helpful for the Ministry of Health to provide guidance and expectation of service. This group could be an exemplary hub of learning and knowledge exchange to improve mental health and addiction services with clear performance expectations.
* The section on what great might look like in 10 years again seems to represent current knowledge of good continuous quality improvement practice, which is probably already in place in many parts of the country. However what is missing is national consistency. There is considerable variability in access to and quality of health services across New Zealand, more than is justified by regional differences. Greater consistency in service quality and access requires national leadership and outcome monitoring systems to hold individual DHBs accountable for more than a small handful of targets.
* We suggest that this section needs to align with current development of the national population outcomes framework, and the commissioning framework. National leadership is paramount in achieving national consistency. We still see local initiatives that vary considerably from each other, and support more opportunities to understand what is working well and what is not and therefore enable learning from good practice models.

**Action 7:** *The Ministry, working with the HQSC, will develop and implement service user experience measures. This could build on the HQSC’s existing work with online patient experience surveys.*

* We support the development of service user experience surveys, especially amongst mental health, addiction and disabilities service users. These should be developed with strong service user input, leadership and direction to ensure information collected is about what is important to the quality of life of the person receiving the service.
* We would support DHB KPI and PRIMHD data being made publicly available, similarly to a health trip adviser or ERO reports for schools. Currently this data is hidden from view. PRIMHD outcome data could be made available via an information portal.

**Action 8:** *Develop and implement a health outcome-focused framework, with involvement from the health and disability system, service users and the wider social sector. The framework will reflect the links between people, their needs, and outcomes of services and will shift the focus from inputs to outcomes. This work will build on the Integrated Performance and Incentive Framework work to date, and aims to increase equity of health outcomes, quality and value.*

* We support the development of a health outcome-focused framework. However national health surveys need to be regularly undertaken to inform and monitor this kind of framework. We note that the last national mental health survey (Te Rau Hinengaro) was published in 2006.

**Action 9:** *Work with the system to develop a performance management approach that makes use of streamlined reporting at all levels, to make the whole system publicly transparent. This will draw on service user experience results (developed through action 7), operate within the outcomes framework (developed through action 8) and involve approaching planning, monitoring and continuous improvement in a tight–loose–tight way (ie, setting specific target outcomes, making service delivery options flexible, and being tight on achieving health and equity outcomes) and supporting innovation.*

* We support the development of a performance management approach as outlined.

**Action 10:** *Align funding better across the system**with a rolling programme focused on getting the best value from health investment (including incentives where relevant to support Strategy direction).*

* We support increasing access to health services for those most in need, and especially for people living with serious mental health problems. We note that access to primary health care can be compromised for this group, and would like to see this situation remedied as physical health problems create unacceptably high mortality and morbidity amongst mental health service users.
* We note that oral health is a major problem for people with serious mental health, addiction and disabilities problems, due to the mouth-drying effects of many psychiatric medications, and that access to dental health services is not subsidised for this group.
* However as previously noted, we also support the principle of proportionate universalism.
* We would like to have transparency about the application of the population based funding formula (PBFF) for DHBs, so that everybody is assured that they are getting a fair share of the available resources. Recent research indicates that this is not currently the case, with Capital and Coast and Auckland DHBs in particular not receiving their population share of Vote Health resources[[7]](#footnote-7). We request urgent consideration of this issue if this inequitable situation has not already been addressed.
* We support improvements in the quality of commissioning of health services, and would support a review of the funding model for primary care.

**Action 11:** *Develop and use a health investment approach**with DHBs. This could be used to target high-need priority populations to improve overall health outcomes, while developing and spreading better practices. This will increase knowledge about population segmentation, drive collaboration, build skills in developing investment cases in the system, improve visibility of value for money, and build on the New Zealand Productivity Commission’s recommendations around a learning system.*

* As previously noted, we support increasing access to high-need populations, but the targeting of health resources to very vulnerable groups should not be done at the expense of others who are also in need and unable to access services.

**Action 12:** *Continuously improve system quality and safety.*

* We strongly support the focus on continuous quality improvement, and particularly in primary care and rest home care.
* Of particular concern is the impact of practices like seclusion and restraint in mental health services, as these create trauma. Quality and safety processes in these services should include as a priority, the reduction of trauma for people receiving services.

**4. One team**

1. We support the arguments put forward in this section, and particularly those which identify the need for a well-supported health workforce, with leadership being a critical component.
2. We particularly support the strengthening of NGO capability in mental health, addiction and disabilities services, and the fostering of leadership throughout the health and disabilities sectors.
3. We welcome the ‘system leadership’ role of the Ministry of Health as outlined on p. 22. We caution that being flexible about how health services are delivered ought not to result in significant variation in people’s access to and the quality of service around the country. We support the Ministry’s leadership role to focus on national consistency, alongside flexibility in response to local need. National consistency ought to include the Ministry being responsible for the oversight of clinical guidelines across all parts of the health sector.

**Action 13:** *Improve governance and decision-making processes across the system, through a focus on capability, innovation and best practice, in order to improve overall outcomes.*

* We support improvements in governance and decision-making processes, particularly at DHB level.

**Action 14:** *The Ministry of Health will work with leaders in the system to improve the cohesion of the health system, including by clarifying roles and responsibilities/accountabilities**across the system as part of the planning and implementation of the Strategy.*

* We support efforts to improve cohesion in the health system.

**Action 15:** *The Ministry of Health, with input from the system, will establish a simplified and integrated health advisory structure**that oversees health system changes and incorporates or takes into account relevant existing national committees (eg, the National Health IT Board, the Capital Investment Committee, Health Workforce New Zealand, the National Health Board, and the National Health Committee)*.

* We support a simplified health advisory structure that is made clear to stakeholders.

**Action 16:** *Put in place a system leadership and talent management programme and workforce development**initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility.*

* We support the actions outlined in this section, especially those related to quality improvement and clinical leadership. However we note that there is no specific mention of clinical guidance, and strongly recommend that the Ministry of Health provide national leadership in this area, and across all components of the health sector where clinical guidance is required.
* We would like to see that all DHB districts are required to develop workforce development plans that take a strategic approach to future workforce development. This will potentially require different plans for different parts of the DHB ie mental health, addiction and disabilities, health of older people. These plans need to take a district approach which are inclusive of community NGO health services as well.
* We also need identified strategies to ‘grow our own’ workforce as we cannot rely on the migrant workforce to fill shortages in supply.
* Leadership capacity and capability is required both at a clinical leadership level and also people leadership to manage the change that will be required to achieve the goals and action of this strategy. We also see the need to grow service user leadership for mental health, addiction and disabilities, and suggest that HQSC work should routinely include service user input.
* We strongly support e. which identifies the need for workforce capacity planning for the carer (including family and whanau) and support workforce. This is especially relevant for the mental health, addiction and disabilities workforce. It also needs to include the service user and peer support workforce.
* We support the use of workforce data to inform workforce planning and development. This needs to include a co-ordinated system for the collection of workforce data across the DHB and NGO sectors. This is essential to adequately plan for future workforce requirements.

**Action 17:** *To create a ‘one-team’ approach for health in New Zealand, the Ministry of Health will facilitate whole-of-system forums annually (in advance of DHB planning), to discuss government priorities, share international and New Zealand best practices and build leadership. Forums will inform advice to the Minister of Health on system priorities on an annual basis and contribute to a culture of trust and partnership.*

* We support the idea of whole-of-system forums in principle, but question how much can be achieved through bringing together very large groups of individuals for a short time once a year. This will only be workable if there is a lot of ongoing preparatory work done with stakeholders. Multiple forums with a very focused agenda may be more effective.
* We support the sharing of examples of good practice and innovation.
* Workforce development will need to be a key focus of these forums to ensure there is the capacity and capability within the workforce to respond to the priority areas.

**5. Smart system**

* We support the points made in this section about the need for information to be reliable, accurate, and accessible, and suggest that national leadership is needed in this area. The sharing of quality data for a better health system is essential, and this is important not only at a national level but also at regional, local and service levels. Information also needs to be used to improve service quality.
* Variations in IT infrastructure between DHBs impacts on the continuity of service between regions and districts through the inability to share information. This issue is greater for NGOs.
* We agree with having strong analytical capability to transform individual data into the knowledge required to accurately and effectively target services to meet people’s needs; our comment is that this work should be undertaken in parallel with the SMART work.
* The targeting of services to assist the delivery of priority social outcomes is important, particularly the inclusion of social outcome indicators in the mental health, addiction and disabilities sector.
* We agree that social indicator data that is collected needs to be incorporated in treatment planning and shared with service users. Currently the collection of social indicators is a compliance exercise and the value of this information is not being released as part of collaborative practice.

**Action 18:** *Increase New Zealand’s national data quality and analytical capability to improve transparency across the health system*

* It is important to progress analytical and the research networks to inform decision-making. We support the move to work with other government agencies to improve cross-sectoral action. Linkages to social indicators, such as those used for Whānau Ora and youth services might support and facilitate a more ‘holistic’ approach to looking after the person’s health.
* We agree that increasing Ministry of Health analytical capability is very important, particularly in the mental health, addiction and disabilities sectors. We suggest considering collaboration with other sector agencies to assist with this process. For example, Te Pou can assist with utilising PRIMHD data.

**Action 19:** *The Ministry of Health will establish a national electronic health record that is accessed through certified systems including: patient portals, health provider portals, and mobile applications*

* It is important for mental health service users that information on a shared electronic health record is limited to the medicines prescribed and does not include the mental health diagnosis, to avoid the stigma attached to many mental health diagnoses and the potential for ‘diagnostic overshadowing’[[8]](#footnote-8).
* Service users should have access to all their own health information and notes. Where outcome measurement data is being collected it should be mandatory to share this information.
* Data needs to be linked as is appropriate. An example is patient general practice data such as a change in contact details, which needs to be linked with Breastscreen Aotearoa.
* Standardisation to ensure high-quality data is accessible by certified health applications could be linked to PRIMHD, or built around the PRIMHD infrastructure. This needs to be connected to the IDI system with appropriate security level access so we don’t have different systems for different 'conditions'. PRIMHD is internationally unique and a rich data source that is under-utilised.
* The concept of certified mobile phone ‘health apps’ that can be used with confidence is supported in principle, but only after significant work has been done on the security, privacy and confidentiality of information stored on Apps and electronic records or in the cloud.

**Action 20:** *Develop capability for effective identification, development, prioritisation, regulation and update of knowledge and technologies. This action area seeks to improve the health system’s service effectiveness, reduce cost, improve engagement with people who access health services, promote healthy behaviours and self-management, and aid people-led design. It includes the use of new technologies (medicines, medical devices from dressings to robotics, cell and tissue therapies), service design/models of care, and information technology.*

* We support activities which strengthen the impact of health research and technology, particularly those which aim to increase capability to improve engagement with people who access health services.
* New Zealand has a very good record of innovation in this area, especially in facilitating more effective consumer access to health services. Websites such as Health Navigator and tools demonstrating innovative and effective use of electronic technology such as the eCHAT tool which has been successfully trialled within primary care, should be better supported and where possible, integrated into health systems.
* We support the development of a regulatory scheme to support the assessment and uptake of medical devices and therapeutic products. Many therapeutic devices and products available in NZ currently have very limited evidence for effectiveness. There is significant potential for harm in an unregulated environment.

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| **286** | Submitter name | Dr Dale Bramley |
| Submitter organisation | Waitemata District Health Board |

4 December 2015

New Zealand Health Strategy Consultation

Ministry of Health

PO Box 5013

Wellington

Re: **Waitemata DHB feedback on the draft New Zealand Health Strategy**

Thank you for the opportunity to provide feedback on the draft New Zealand Health Strategy. Waitemata DHB is providing the attached submission as part of a Northern Region submission.

We have been involved in the consultation process on the refreshed strategy throughout 2015, including the most recent opportunities with the release of the draft Strategy. We have provided input into the consultation along these various stages, at different levels and in different forums. We are pleased to provide further feedback on this final draft Strategy.

The Strategy refresh is a significant opportunity to provide leadership and direction in health. Overall the strategy is simple, concise, and easy to read. It acknowledges that there have been challenges in delivering on the principles articulated in the 2000 Health Strategy, and that broad examination systems and funding are important in order to recommit to those high level principles while stretching them further to add collaborative interagency working. Some key areas we are very supportive of, and which align to DHB direction of travel, are the focus on people-centred services, co-design, system thinking, and priority areas of children and whanau and long term conditions. We note and support the increased focus on collaborating across government (examples given include the Social Sector trials and Children’s Teams) and the indication of expansions of these approaches and new funding approaches to support this. We also support the commitment to the development of a national electronic health record and sharing of health information to support targeted intervention, integration and monitoring of outcomes.

We believe the strategy could be further strengthened. The focus on prevention, early intervention, long term conditions, children and families are important and supported. Focused evidence based actions, supported by the signalled health investment approach, are not clearly visible in the roadmap of actions. The actions appear to be a continuation of current activity. In our submission we have provided suggested ways to improve the link between the sections, and clarify the actions themselves, to meet the vision of equitable population wellness articulated in the document. Key areas could include population level strategies for long term conditions (including obesity, alcohol, tobacco control, cardiovascular disease, cancer and mental health); a focus on improved outcomes key population groups (ethnic-specific but also key groups such as older people and mental health); and an empowered and enabled workforce and population able to navigate conversations and care delivery in the most appropriate way.

We appreciate the opportunity to provide commentary and look forward to the release of the final strategy.

Yours sincerely,

Dr Dale Bramley

Chief Executive Officer

Waitemata District Health Board

Update of the New Zealand Health Strategy

All New Zealanders live well, stay well, get well

Consultation draft

Submission form

**Waitemata DHB Submission**



### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| The strategy justifiably emphasises a number of strengths of New Zealand’s health system. We believe however that there are some key areas which pose significant challenges that are not presently addressed, and some key opportunities to address them that relate to the principles and themes in the document. While we understand that this is a high level strategic document we believe that the articulation of some additional elements strengthens the ‘intervention logic’ translation of principles and strategic themes to the roadmap of action. There is not currently a clear correlation between the two sections of the Strategy and this could be a way to achieve more continuity. * There could be clearer articulation of the financial challenges of growth in our older population (driving significant health expenditure), the impact of long term conditions, and demand for access to high cost targeted drug therapies. Some DHB stakeholders felt that the need for change (working differently and funding differently) does not appear to have a clear basis in this section. The document does not clearly articulate how to resolve the financial tension between doing more cross-sectoral and prevention/early intervention work (which we support) and still managing to provide treatment services (with substantial population growth and continuing to ‘do more with less’).
* The challenge of long term conditions is noted; however the road map does not clearly address how to continue to accelerate progress in the key conditions of cardiovascular disease and cancer. We recommend providing several key well defined initiatives or agreed actions in the roadmap to address these key drivers of morbidity and early death (with a focus on groups disproportionately burdened).
* End of life care and advanced care planning are important challenges related to an aging population and long term conditions. Workforce development is a key opportunity in these areas. Patients need to be guided through often overwhelming information; and clinicians need further and focused training to navigate these conversations. Empowering our workforce and our population, and refocusing on *care* and our co-produced DHB values are concepts which stakeholders felt could provide opportunities to address some of these challenges. *Care* for both our workforce and our population was a theme highlighted by DHB stakeholders.
* Technology is important enabler and is rightfully included in the document however there is a disproportionate focus on technology without acknowledgement of workforce development (including appropriate use of multidisciplinary/multiservice/multisectoral team members), communication skills and cultural competency. The same skills are needed for long term condition management discussions and facilitating self-managed care as for advance care planning and end of life care. This involves different ways of communicating and new skills for all health professionals, and for ensuring our workforce is equipped to work at the top of their scope.
* The challenge of delivering equitable outcomes across population groups is mentioned once in this section and yet does not translate well to key opportunities or to the roadmap of actions. There are significant opportunities in prevention, early intervention, targeted resources and primary care access that can address inequitable outcomes. We believe that consideration of ‘all New Zealanders’ does not address this well.
* Ensuring we have the appropriate level of health services for the local population and how these are structured in the most appropriate way to be effective are important elements to DHB planning that could be reflected in the document. DHB involvement in planning better for the most appropriate primary care access in specific locations is an important opportunity that could be addressed. By that we mean working with our primary care providers (including private providers) such as general practices, pharmacies and NGOs in the community on what the appropriate place, number, and level and mix of service delivery is (‘right sizing’) to ensure primary care is accessible and delivers appropriate and equitable health outcomes. The Strategy does acknowledge issues for Māori and Pacific populations in accessing primary care services; however the opportunities to address these access barriers are not further addressed in the remainder of the document or in the actions.
* There is a need to ensure the strategy has a clear and explicit focus on equity to achieve Māori health gain. Initiatives that promote equity invariably lead to improved health for all. But initiatives aimed at improving health for all customarily either maintain or increase inequities. The health inequities experienced by Māori in our region include barriers such as access to and through services, service design, quality and safety and data quality. Opportunities in this area include increasing our Māori clinical workforce, Clinician and whānau health literacy, service redesign and improving cultural competency and responsiveness. There is a requirement to consider the needs of Māori exclusively from other high needs and vulnerable populations given the expectations as a Treaty of Waitangi partner.
* A key challenge in the wider Auckland region is reflecting Asian population growth and super-diversity within our services. The health disparities experienced within Asian subgroups due to barriers such as accuracy of ethnicity data, access and utilisation of health services (in particular primary care) are important. Opportunities in this area include language and progress towards a culturally competent health workforce. There is a real and emerging need to focus on Asian health as a key priority group alongside Māori and Pacific, rather than consideration under ‘Other populations.’ We also note that there is no reference to ‘refugee’ populations throughout the document, given their high needs and barriers to access and utilisation of services, language and complex health needs.
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### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| The focus on system alignment towards a shared vision and outcome of wellness is one shared by DHBs, articulated through our Outcomes Frameworks (DHB Outcomes Framework and Māori Health Outcomes Framework *Nga Painga Hauora* developed with Sir Mason Durie). The strategic themes articulated in the statement are supported by DHBs. We would like to see more clearly identified actions to operationalise this vision through the strategic themes and roadmap.Many DHB stakeholders felt that the term ‘all New Zealanders’ reduced the emphasis on equity rather than enhanced it. Particularly because the Strategy retains three key principles related to equity, including its commitment to the Treaty of Waitangi, the statement ‘all New Zealanders’ appears to undermine this position. If actions to address equity were a more prominent feature in the roadmap actions this issue may be less prominent. Several stakeholders would prefer equity to be explicit in the vision. |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| The original New Zealand Health Strategy 2000 principles remain sound. There is broad based DHB support for the addition of the new principle providing a broader definition of health and cross-sector working to realise the impacts of the health system on social outcomes, but also the impact of the wider socioeconomic determinants on health outcomes (eg housing, education, employment, poverty). * We are supportive of the new principle and indeed have made progress in these areas with inter-sectoral collaboration at a number of levels for example in the Auckland Social Sector Leaders Forum, Healthy Auckland Together, the Rheumatic Fever Prevention Programme and in the vulnerable pregnant women and vulnerable children’s work programmes. These forums and ways of working are still in development and many are working towards collaboration rather than achieving it yet.
* Genuine partnership and collaboration takes a lot of energy and resource and at times remains elusive despite significant goodwill and passion. We would like to see much clearer activity in the roadmap to indicate how this will be resourced and enabled (for all partners) and how this will be measured, evaluated and appropriately strengthened.
* Evidence of genuine collaboration at all levels (from the Minister and Ministries down) was an important element noted by many DHB stakeholders. The ability for other sector partners to understand and articulate (‘speak for’) health is an important element of the success of health system interventions with benefits for other sectors (eg the Better Public Sector targets), and the impact of other sectors on health outcomes (eg housing quality on preventable hospitalisations).
* Local ability to influence and facilitate action (and accountability) in the key areas outlined in the draft Strategy could be enabled in a range of ways including moving some services currently held nationally to a regional/district approach eg disability services, mobility teams, Plunket and Lead Maternity Carers. DHBs should be held accountable for the delivery and stewardship of the local health system to achieve government policies, under clear and concise Ministry standard setting, but with considerable freedom to delivery those achievements as appropriate for our populations.
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### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| The five themes are acceptable although some DHB stakeholders felt that they appeared more as a collection of ‘good ideas’ rather than a coherent approach. Some stakeholders felt that they could be stated in a more inspirational way. * **People-powered** addresses co-design, individual responsibility for health and health literacy which are all important elements to consider including funding implications. We are already working on these elements in the DHB and appreciate the technological enablers of this approach. The workshop consultation sessions suggested that equity could be considered under the people-powered section (it is not currently and this would strengthen the section). One possible way to do this is to change the theme to **People-powered, Equity focussed** We need to also ensure that patient empowerment and engagement approaches (which we support) are not only taken up by those with the most resource as this provides potential to increase inequalities. The section on People-powered could also address the workforce eg (a) populations and patients and (b) health professionals, providers and inter-sectoral workforce. Further connections between leveraging data and population segmentation approaches under Smart System could be linked to People-powered through improved and consistent offer of services/interventions to the ‘right’ people to improve access and self-management of their health would also strengthen the section. **Community -centred** rather than People-powered was felt by some DHB stakeholders to encompass the key NGOs, community groups, and other providers (including cultural and disability associations) as key players in their ability to ensure the needs of diverse groups are incorporated into the co-design of interventions, programmes and services, particularly those where language is a barrier.
* **Closer to home** was an area where DHB stakeholders had divergent opinions. Some felt that this was ‘business-as usual’ with ongoing efforts to reorient the system towards improved access to primary services, prevention and early intervention including progress with Whānau Ora centres, Healthy Village Action Zone and Enua Ola. Overall DHB stakeholders voiced strong support for a greater focus on primary and community services (including selected secondary services as is underway in a number of initiatives such as Whānau Ora centres and the Tamaki Regeneration Project), however expressed concern that funding reorientation needs to follow system change. There was universal support for the need to focus on children and whānau and long term conditions. However prevention, early intervention and broader government policy drivers (noting the inclusion of the recently released obesity strategy) were not addressed in this section or in the roadmap. Some stakeholders felt that there was not enough evidence for why closer to home should be a key focus above other areas. The section does not mention that there are some instances where improved efficiency can be gained from regionalisation or centralisation of some high cost or specialised services. Stakeholders also note that there is likely to be a trade-off between providing more services locally and making other investments such as prevention, improving equity or providing access to drugs and interventions that prolong life such as advanced pharmaceutical therapies (eg for Hepatitis C and melanoma). **Convenient and timely access** was felt by some stakeholders to conceptualise the range of best access points across population groups and services.
* The outcomes focus of **Value and High Performance** was felt to be in alignment with DHB direction. Information drivers and performance measurement were well supported but stakeholders did not believe that the roadmap addressed how this was to be operationalised in enough detail given how much work has already gone into these areas. Again equity was noted here but this appeared to be limited and had no associated roadmap actions. This appears to be a missed opportunity to ensure that equity of outcome is consistently applied as part of the value/investment /performance equation (as DHBs are legislatively mandated to do to address health inequality). There is opportunity here to include equity as a key health and wider system performance measure and to refocus funding to achieve this. DHB stakeholders considered responsive services (culturally responsive and responsive to patient experience and to people with disabilities) to be a key performance measure in itself.
* The components of the **One Team** theme were generally agreed noting that true integration remains a challenge and opportunity for DHBs in many areas. The term ‘flexible use of the workforce’ was challenged although and a related concept was suggested in preference: that new models of care enable all members of the workforce (including the emerging area of care navigation) to work to the top of their scope. It was noted that health navigators (a workforce that is not-well-defined) are becoming ‘the answer’ in many parts of the system. How we train, resource and utilise this new workforce, who are working with some of the most vulnerable and complex patients, still needs much more consideration. The Ministry could provide the leadership in the roadmap on appropriate training pathways, skillset development and cultural competence if navigators are to become core to the One Team approach.
* **Smart System** is again a technology heavy section. We agree that technological solutions are an important element of focus; however Smart Systems should also be linked to multidisciplinary team approaches and to integrated care. Technology also need to be seen as more than enabling patients to make their own appointments and review tests online (although this is important); the potential of technology application to drive more efficient, faster, safer and more accurate care is a broader conceptualisation.
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### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| As noted previously there was felt to be a lack of connection between the generally agreed principles and themes and the roadmap. Part I of the strategy offered potential new ways of working together and suggested a new ‘health investment’ funding approach. * Most of what is in Part II, the roadmap and actions, appears to represent a continuation of current approaches. For example the roadmap does not contain large scale or new actions to match the approaches signalled in the Strategy itself; including in the areas of prevention, technology and people-centred care which are key principles of the document (eg a National Bowel Screening Programme).
* Many of the actions did not have enough detail to determine the potential to contribute to population wellness (the aim and vision of the Strategy), most notably in areas where the Ministry has already undertaken considerable work and where key initiatives could be articulated (eg cancer control, cardiovascular disease, mental health, disability, Māori Health). As noted previously enablers and measurement of cross-sectoral working are not well described.
* Although population based strategies are mentioned there is no activity indicated at this level. Our population is one of the most obese in the world and we have very high rates of alcohol-related harm and domestic violence and well documented issues with inadequate housing and continued and significant burden of ill health from smoking. These are key areas that impact on health and the social sector where there is opportunity for high level policies, population health interventions and interagency collaboration in this area.
* Partnership is mentioned but meaningful partnership with Māori (to achieve equitable health outcomes), a retained core principle of the draft Strategy, appears to be missing from the roadmap.

**Commentary on some of the specific actions:**Action 1: Inform and involve peopleIn the area of self-management education, where technology is very important, there is opportunity to focus on reorientation of the system to support self-management skills and person-to-person approaches enabled by technology rather than focus exclusively on technology.Action 2: People-led designWe support this activity, and indeed patient experience is valued highly in terms of DHB focus. However the action proposes three projects rather than a comprehensive approach or system reorientation which is where the opportunity is. Action 3: Shift servicesGiven that this has been an emphasis of the Ministry and DHBs for a number of years this section appears to lack definition and concrete activity.Action 5: Tackle long-term conditions and obesityd. An important risk was noted under Action 5(d); requiring partnering with only with strong/best performing partners. We are comfortable working with high performing organisations and providers and sharing the learnings across the system as is proposed here, however there is a risk in *requiring* partnerships with those best performing/most equitable providers. Some of our providers have high performance because they deliver services to well-resourced populations. We see significant learnings to be had from providers and organisations working in areas of deprivation or high need and still managing to achieve reasonable performance or more importantly to maintain or improve their performance. We are concerned that requiring partnership only with top performers would risk our support for smaller or poorer performing providers in key localities or populations of interest to the DHB. Losing DHB focus or support could mean that some providers (eg Māori or Pacific providers) services are unsustainable and this would risk our ability to improve equity, choice and patient experience. .e. With regards to population segments, greater effort must be directed to Māori and Pacific ) population groups in targeted prevention, promotion and early interventions for diabetes and cardiovascular disease. Targeting interventions to some high risk Asian subpopulations (eg Chinese and South Asian) will become increasing important in Auckland. Actions in this area should support sound moved from risk assessment to appropriate management. The Diabetes Service Level Alliance in Auckland DHB and Waitemata DHB is an example of planned activity to make this shift.Action 6: A great starta. This action needs to include tobacco (the health target of reducing smoking at two weeks post partum would support this addition).Action 8: Improved performance and outcomesDevelop and implement a health outcomes framework. We have DHB outcomes frameworks and a Māori Health Outcomes framework *Nga Painga Hauora* among other service level outcomes frameworks developed or in progress. We are aware of the importance of measuring outcomes to determine whether we are meeting need, however determining/attributing contribution of an intervention or programme to that outcome remains challenging. We note our position that it is important that we continue to report intermediate outcomes/outputs that we can be confident are linked to outcomes (by evidence) and are clear about our contribution to these. We are happy to work with the Ministry on reducing the administrative burden of our current performance reporting and reconsider selected outcomes and programme outputs in terms of ongoing monitoring. We have begun such a process in our integrated contracting approach with Pacific and Māori Providers under the Māori Health Outcomes Framework *Nga Painga Hauora*.Action 11: Target investmentsThis action appears to suggest that investment approaches are not currently undertaken by DHBs. We are open to understand more about the proposed health investment approach; however the information provided in this action is not clear about what this would entail. We understand and welcome the need to look wider than health benefit from health interventions, and support new investment to explore and robustly evaluate this approach. This approach, however, does not appear to be an appropriate basis for all wider health funding.Action 12: Quality and Safetya. This action refers to rest homes and we note that this should be residential care. Quality in residential care is important area but the Roadmap action does not have enough clarity on this point.Action 16: Build system leadership, talent and workforceWorkforce development needs to include a focus on empowering providers of care and the population (as noted above) and to enable inclusive approaches to addressing inequalities (including the range of disabilities). Health literacy, in its broadest sense (organisational literacy and patient literacy) is a useful mechanism to facilitate this development and the DHBs have health literacy approaches in progress to begin this work.Action 18: Strengthen national analytical capability People are increasingly able to interact with the health system online – this requires online functionalities to provide information to users in their preferred language with funding earmarked for ongoing support. English should not be the only language option available to individuals who wish to access information about the health system online.Action 20: Strengthen health research and technologyIt is important to acknowledge that a lot of useful health services analysis, research and evaluation is conducted in DHBs and within providers. This can be usefully strengthened, rather than the singular focus on the Health Research Council suggested in this action.   |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| There is a growing call for equity focussed health reporting. An approach that mandates equity focussed reporting will best support an ongoing focus on achieving health equity. Currently, service providers can reach health targets for ‘all New Zealanders’ while failing to reach the same target for Māori or other priority populations. For example a breast screening provider may ensure that 80.9% of New Zealand Europeans access a service, but only 61.5% of Māori, resulting in a total population result that nearly reaches the 70% target. There are a number of ways to require, provide and enable equity focussed reporting across the sector and we recommend leadership and investment in this area. |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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**Appendix**

**The Draft New Zealand Health Strategy Submission: Additional feedback from Waitemata DHB Board Members**

# Overall comments

Several board members indicated that they felt Part I of the document described ways of working rather than key population priority areas of focus. Members indicated a desire for the Strategy to articulate or highlight key population group or disease group priority areas. It was felt by some members that specifying these priority areas focussed attention on implementation and action which aligned to the health gain and outcomes focus of Waitemata DHB, and provided aspirational targets against which progress can be measured.

One member involved in the 2000 New Zealand Health Strategy noted that the previous 13 population health objectives (listed below) remain relevant and that their inclusion in the Strategy had important impacts, for example improved visibility of the issues of family violence and suicide.

New Zealand Health Strategy 2000; 13 Population Health Objectives

* Reduce smoking
* Improve nutrition
* Reduce obesity
* Increase physical activity
* Reduce suicide
* Minimise harm from alcohol and drug use
* Cancer
* Cardiovascular disease
* Diabetes
* Oral health
* Reduce violence
* Improve health status of people with severe mental illness
* Enable access to child health

Some members commented on what they felt was a lack of substance on actions to improve equity. One member noted the loss of the statement in the 2000 New Zealand Health Strategy that healthcare would be accessible when it was needed, regardless of ability to pay. This statement was felt to be essential to underpin equity objectives (which are stated in Part I of the document) and recommended that this statement be also included in the refreshed Strategy.

# Specific Action Area comments for the Roadmap

**Action 1:**

Telehealth is a technology that can be used to specifically enable treatment closer to home and decrease unnecessary hospital transfer. One member felt that an additional reference could be made in Action point 1 (d) on improving the educational aspects of healthcare provider training in informed consent and shared-decision making. These have been shown to both improve satisfaction and decrease healthcare costs.

**Action 3:**

Where evidence exists that some specialist services should be delivered in only one or some locations those specialist services should be rationalised to these locations to improve health outcomes. Where evidence exists suggesting some conditions need to be dealt with in high volume centres, we need to shift services centrally, but where this is not the case those services could be shifted closer to the patient. For example, we currently perform Ivor-Lewis Oesophagectomy in multiple hospitals in New Zealand with unacceptably high morbidity and mortality rates. This is a procedure that could probably be performed in a single centre for safety reasons.

**Action 8:**

Include consideration of the wider patient journey, whole systems of care, pre-hospital care and transfer of care, and clinical networks in the consideration of health outcomes frameworks, performance, value and governance.

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| **287** | Submitter name | [redacted] |
| Submitter organisation |  |



[redacted]

Research Centre for Maori Health & Development

College of Health

Massey University

Albany Campus

[redacted]

4 December 2015

### Submission on the Update of the New Zealand Health Strategy

Ko Ngatokimatawhaorua te waka. Ko Ngā Pui Nui Tonu te iwi. Ko Marewa Glover toku ingoa. I am an Associate Professor with Massey University’s Research Centre for Māori Health and Development. I am a Behavioural Scientist with a long career in Māori health solidly focused on addressing the big challenges for Māori health – mainly how to reduce smoking prevalence. I am a leader in tobacco control and am internationally recognised as an expert on electronic cigarette vaping in New Zealand. Because of my time working for the Public Health Commission in the early 1990s, I understand the need for innovative, pragmatic and cost-efficient health interventions. My recent projects have thus trialled incentives, competitions, the use of internet based technologies and gaming to facilitate behavioural change. I have designed a number of effective interventions that have been adopted by the Ministry of Health for national roll-out or extended regional trials.

Having read the draft Health Strategy I would like to offer make some comments:

*Health in Context*

It is good to see an attempt to sit health within its wider context. The health status of New Zealanders needs to also be thought about within the wider context of the world and the state of all people's health globally. Against international benchmarks New Zealand is one of the richest nations in the world. Our people enjoy an abundant lifestyle compared to many other peoples in the world. New Zealanders can look forward to a long and relatively healthy life.

We need to stay cognizant of our place in the world and ask the question: how much is enough? How "well" do we ALL need to be? Are we agreed as a nation that we want to achieve a nation status alike to that depicted in the science fiction movie *Elysium*? As an Island state, do we falsely believe that we will be able to live so differently from the world's billions who are malnourished, unwell, exploited, nationless? That we can aspire to ALL live as well as the world's richest people?

Many New Zealanders are concerned about climate change, global population control, industrial and cultural globalization, and the revelations about just how wide the disparities are between the world's richest people and the majority of the rest of the people on earth?

A business model approach to health, which I think is underpinning the draft Health Strategy rather than a social entrepreneurial approach, is likely to contribute to wider disparities that will one day lead to a French or Russian type revolution of the people (the 'disadvantaged') to force political and social change.

Our connectedness with the world is two-way, not unidirectional as depicted in the Strategy which only talks about what we can learn and take from the world. New Zealand has at times been a leader in health, e.g. our Smoke-free Environments Act 1990. We are both a role model for other countries and as such have a responsibility to consider our impact on the world not just it's impact on us.

Moving to a desire to have a health system that results in **all** New Zealanders **living well and staying well** is unrealistic. How is "well" defined? Will we all be well when we each own our own mansion overlooking the sea? Will "well", as implied in the health strategy, be self-assessed? If so, we only need keep people ignorant of their 'disadvantage' and doped on alcohol, cannabis, tobacco and an endless stream of mind-numbing television and retailer advertising, so that they don't realise they are not as well as the people in the top 3% of highest incomes.

The health system needs to stay primarily focused on healing the abused, the sick and the injured and caring for the infirm, the elderly and uplifting the health status of the differently abled; and protecting people from dangerous people and dangerous businesses and products; and ensuring equity in delivery of health outcome.

One unique opportunity that New Zealand has is to learn more from Māori about how things could be done differently to achieve more rapid improvements in health. Our Indigenous wisdom is largely overlooked or commodified for tourist and recreational consumption. The ability to view the great challenges in health from a uniquely Māori Indigenous perspective could have benefits not only in Aotearoa but further afield.

*The Treaty of Waitangi*

The Health Strategy acknowledges that the Treaty of Waitangi establishes a special relationship between ngā iwi Māori and the Crown, but nowhere else in it is the Treaty obvious. I agree with Te Ara Hā Ora’ who recommend in their submission that Te Tiriti o Waitangi be given higher priority and consideration in the final Strategy.

The Treaty of Waitangi and the historical failure of successive governments to reduce the harm that was done to Māori and continues to be done to Māori, demands that Māori remain an identified priority group against which others are measured. If others are doing better than Māori then they should take a back seat until Māori have been caught up. Only when Māori enjoy the national average health status is it fair to focus on the health of “ALL” New Zealanders.

It is very important to ensure that population groups receive equal benefits from the health and disability system, but particularly this is so for Maori who first were drained of health by colonization and since have experienced neglect.

Year on year on year government refuses to make Māori woman's dire situation a priority for action and year on year little changes for them. We have had only a 1% drop in smoking prevalence per year over the last 10 years! This is not equitable! You must include reduction of smoking while pregnant. The absence of this continues an historic negligence towards Māori woman leaving over 60% of Māori children exposed to smoke in-utero and damaged before they are born. This impacts on later obesity, learning difficulties, and many of the health problems the Strategy claims it will address. Far more Māori children are affected by tobacco smoke exposure in-utero than by fetal alcohol syndrome. We need to increase support to all pregnant Māori women. Over 50% smoke and they may not self-disclose this when using health services. It is time to redirect tobacco control funding from working on smoke-free parks and streets and plain packaging and smoke-free house and car promotions and move it all into smoking cessation for Māori women of childbearing years (including Cook Island women, Niuean and Samoan women).

*Reducing Tobacco Smoking Still Needs to be a Priority*

Tobacco smoking still presents the biggest threat to health and remains modifiable. Over 600,000 people in New Zealand still smoke. However, this is likely to be grossly under-estimated as worldwide population surveys are reporting much lower smoking prevalence rates than their tobacco consumption figures suggest is true. New Zealand is likely to be the same with strong stigma attached to smoking increasing the likelihood of social desirability bias undermining the validity of the health behaviours and census surveys.

Many of the selected health problems given a focus in the draft Health Strategy are exacerbated by tobacco smoking or exposure to tobacco smoke (rheumatic fever, respiratory conditions, poor educational progress, behavioural problems and criminality; diabetes, cardiovascular disease and many cancers; mental health and drug and alcohol misuse; cot death).

The rhetoric about shifting to a focus on prevention is encouraging but sometimes this does not result in sufficient change for those already suffering. For example, tobacco control are focused on preventing uptake of smoking among young people and are leaving current smokers to die. The reality is children are losing their parents and grandparents – we need to stop the disease and death caused by smoking FIRST before we turn to protecting healthy people from a whiff of tobacco smoke (i.e. the disproportionate amount of time and effort going into making outside environments smokefree and plain packaging).

Money can be saved by a more directed focus on highly modifiable behaviours. For example, rather than spending on a shot-gun mass media approach to change the nation's attitude to drinking alcohol (by demonising alcohol use even when drunk in small non-harmful quantities) the Government should focus its efforts on problematic alcohol use and the sub-groups who are having problems because of their alcohol consumption. Similarly, tobacco control needs to stay firmly fixed on reducing tobacco smoking (the harmful behaviour) and desist from blocking people's choice to use innovative harm reduction approaches, such as, vaping nicotine.

The Strategy wants to "target services to meet people's needs". Tobacco control can be directed to just smokers, for example, the idea of a smoker’s register would be able to be a reality in the system proposed.

*Obesity.*

The strategy suggests that obesity is becoming more common. There are large disparities in obesity rates and each ethnic group is at a different stage of the epidemic. For example, whilst there has been a rise in obesity for Pākehā women, the rates have stayed stable for Māori and Pacific. The wording here is a bit misleading and tries to sensationalize the increase in obesity rates. It is as if obesity is suddenly all important because obesity is now increasing among Pākehā.

*A note about tobacco smoking & obesity*

The claim that obesity is expected to overtake tobacco as the leading cause of ill health doesn't mean you should drop tobacco! 42% of Māori women smoke, more so in their childbearing and parenting years. Helping them stop smoking remains an absolute priority for action. It is also not useful to compartmentalise these disorders. There are many Māori women who are both smokers and overweight or obese. These problems cannot be dealt with in isolation of each other. For example, one of the reasons why Māori women’s smoking rates remain high is that fear of weight gain and actual weight gain post-cessation is a very real barrier to sustaining cessation. Smoking cessation approaches need to be dealing with both stopping smoking and weigh control and increasing physical activity. Conversely, obesity and weight loss programmes need to provide smoking cessation assistance.

*Recognition of the importance of research.*

It is good to see a reference to growing the evidence base. The strategy promises a commitment to innovation which will sometimes require making evidence-informed decisions until the evidence base exists.

The Strategy claims that “New Zealand has outstanding and internationally recognised research teams…” Unfortunately internationally recognised Māori researchers are not nurtured in the current system.

"We need to get better and faster and sharing the best new ideas and evidence and putting them to work throughout the system". But who decides what’s best? It needs to be a negotiated position especially since researchers are highly conflicted to protect their status, funding and thus some unique value proposition. The health research environment is highly competitive and often the funding imperative takes precedence.

The Health Strategy wants to effectively draw on and utilise global ideas. This needs to be tempered with local Māori and Pacific knowledge. Often interventions from the UK or USA are just copied and they don't work or they makes things worse!

The strategy acknowledges that we have a strong and growing knowledge base. It is important to note that that knowledge base is heavily biased towards Western Pākehā cultural views. It must be tempered by a Māori analysis. For too long Pākehā doctors and nurses and teachers have been deciding what the problem is and how to fix it and their analysis is lacking and the solutions don't work. This is almost admitted by some of them, for example, Dr Robin Toomath who recently admitted defeat and said she is giving up the fight against obesity. Perhaps the strategies were not appropriate and acceptable to Māori and Pacific people.

The Strategy envisages that “there is a culture of enquiry and improvement throughout the health system, and seamless links to the New Zealand and international science communities.”

It will be important to enlist multiple researchers not just one and not ‘fairy-ring’ (a group of researchers who believe the same thing and are working in a coordinated way to achieve their own personal success and shared social construction goals that fit their own cultural values and likes). It's important to engage a mix of multidisciplinary researchers and facilitate consensus seeking processes.

The Strategy flags that in five years "the system measures what matters to people". Usually market research is used to find out what matters to people and that is not what is needed. We need quality evaluation of what is effective and what produces outcomes.

*How to move to a more cost-efficient system?*

The current health system is top-heavy with managers and administrators. New Zealand is a small country population wise. The District Health Board system is symptomatic of the opulence: it is expensive and repetitive and concentrates too much funding in the management infrastructure rather than in quality delivery of treatment and care for people. Much of the needs analysis, policy analysis, structural reforms, audits etc can be centralised. The District Health Board system should be reviewed with view to reducing its top-heavy nature and with view to at least reducing the number of District Health Boards.

There needs to be better auditing and accountability to ensure probity and integrity of the service, that is, if it is not delivering what it was contracted to do then the contract should be ended quickly.

There are many ineffective services that could be ended. Old services that have been on the books for over 20 years need to be reviewed.

The lack of visibility of results makes it hard to hold providers accountable.

Use incentives to drive behaviour change.

The “value and high performance” vision for the future is somewhat concerning. This is a business approach. The people who work in health now are largely not for the job alone but for the cause. They will not like this commercialisation of the health system, running it like a profit-making venture, when all that matters is the bottomline - the profit (which in this case is savings that can be drawn back into the government coffers for redirection). It's a conflict of values. People with New Zealand values won't want to work in the proposed system if it is run like a factory. The result will be more people taking a job for the sake of having a job, not because they have a passion for the work. This will be obvious to the New Zealand patient and they will not like it either.

*“One Team”*

The Health Strategy proposes that "we will need to great leaders and managers to enable change." This is stretching the term “leader” – you actually mean administrator. For the job you outline, you need competent managers and administrators. You are not building a business that a leader would want to be part of. Leaders tend to serve the people and serve values that are less focused on profits (or savings). The Strategy claims that the people managing the new Health System will “make the most of the diverse skills in our system, optimise our use of resources and continuously improve our management processes”. To do this you need analysts.

The strategy flags that more effort is going to go into continuously improving management processes and fostering the next generation of leaders. This is concerning as it could signal excessive spending on training courses and people development.

One of the risks of a system undergoing major restructuring (to eliminate resistance) is that there could be a high loss of institutional memory.

*The misuse of “children” as a rhetorical manipulative technique in the game of health politics.*

Children are rarely born into our New Zealand world alone. They in most cases have at least one parent or grandparent who is responsible for their care.

Don't focus on children in isolation. It does not work to make goals about children in isolation. There needs to be an investment in mothers and in lifting the status of Māori woman particularly.

To reduce assaults on children it will be necessary to:

* uplift the status of Indigenous and minority group women
* improve protection of women and children from males who have power & control problems
* prioritise the identification, assessment and diagnosis (mental health) of offenders and get them treatment.

*Improving the health of older people.*

The status of old people needs to be improved. There needs to be better prevention of elderly diseases, stroke, dementia, cardiovascular disease and cancers and improved mobility and prevention of depression.

It is not really appropriate to compare the needs in terms of health and social services between older people and younger people. Older people will stay healthier longer in the future.

Longevity must remain a priority, not wellness. Cultures have different views on the elderly. One risk of shifting focus to wellness as a goal as outlined on page 8 of the Strategy is as they claim people want not just long life but also quality of life which maximises years of wellness. A risk here is that this could be used by some people to justify their opinion that an ailing elderly person has lived long enough and so they feel justified in withholding treatment and food and water to hasten death. The rhetoric of a focus on wellness hides a desire of some in the health system to halt the provision of services to sick elderly people earlier.

*Health navigators.*

I support the use of health navigators especially for Māori and Pacific and groups with low health literacy. However it is important that they are sufficiently funded to cover their running costs so that the cost of health delivery is not simply shifted from the government to communities, especially communities that can ill afford it.

*“People powered”*

The Strategy proposes that the new health system needs to understand people's needs and wants and partner with them to design services to meet their needs. Some people want to use electronic cigarettes to help them stop smoking but under the current system they are not supported to do that or allowed to! The health system is not there to satisfy people’s wants and desires.

There is an opportunity to develop more tailored services especially with better information and with partnering with people and communities. For example, we have been implementing large top down strategies that effect many people rather than just the people that need to modify their behavior. For example, laws are used to regulate and limit the amount of alcohol people drink before they drive. Often it is only a small sector of the community who have problems as a result of a behavior, for example drinking alcohol or smoking. Mass media campaigns broadcast to all viewers including people who do not need to see the message and people who may be harmed by seeing the message. For example, children who have very little exposure or knowledge of smoking are exposed to mass media campaigns teaching them about the harms of smoking and therefore teaching them about smoking. In a lot of cases it would be more cost-effective to target the sector of the community that is experiencing the problem.

The Health Strategy proposes that “health and injury services provide a more consistent experience for people” - across what? Each time they go or wherever they go? This is not necessarily a good thing especially if the experience is not suitable for that person. They may need to go somewhere else where good experience is different.

*Protecting People’s Right To Privacy and Dignity*

The Health Strategy proposes that in the future everyone who delivers and supports services in the health and disability system understands the needs and goals of the individual they are supporting… and focuses on the person receiving care.

They don't need to know *too* much though, just what they need to know. Otherwise they can become *too* intrusive and try to involve themselves *too* much.

*“Smart system” -* I would just caution please collect only what data is required and maintain strong ethical checks and balances.

The proposed new “smart system” envisages that "when people first attend a health service, the provider already knows their details. Their journey and scheduling are integrated." My journey is my business. It is my right to determine what I share or don't share with a provider. This vision is too big brother. Everyone on the health team may not need access to all the information about a person, as is proposed in the Strategy. There is a huge risk of invasion of privacy in what is proposed. The person should control who on the team gets to see their information and which of the information they get to see.

The Strategy goes on to say that "the data we collect is more specific, so that management can be more proactive." I would ask that the data we collect is minimised and management is proactive where needed.

The vision is that "the quality of health care is high as health workers spend quality time with people". I don't want quality time with the nurse or doctor - I'm usually passing through. I want faster effective service. I'm not there to make a friend.

The proposed shared electronic health record system has risks. Would it be an opt in or opt out system? People deserve the right to control their own information and who has access to it.

*Better use of mobile technology and the Internet.*

I support the use of technology and better use of mobile technology and the internet to relay information in a more acceptable and accessible way.

The Health Strategy envisages that people will be able to access practical evidence based health advice that makes it easier for them to make healthy choices and stay well. Technology tools such as mobile devices, smartphones and wearable devices are options for everyone.

There are also other new technologies and devices such as electronic cigarettes. The current Ministry of Health and District Health Boards’ negative position on electronic cigarettes is antithetical to the Strategy’s vision.

The Strategy recognizes that "technology involves more than just digital technologies. Other technologies are revolutionising health systems: robots and other automated systems…" Consumer products may draw people away from harmful products, as electronic cigarettes are doing in the US, UK, Germany and many other countries potentially saving millions of lives. The health system needs to retract from intervention if a consumer alternative begins to do the job more effectively as electronic cigarettes could do for reducing tobacco smoking. The savings would be huge enabling health dollars to be redirected to other more urgent needs.

The action plan includes the proposal to "establish a list of certified mobile health apps that service users and health providers can use with confidence.” This is a nice idea but a huge task. There are tens of thousands of apps released every day in the world. There are already 28,000 health apps. They rapidly evolving and disappear or become redundant. Who gets to decide which are best?

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| **288** | Submitter name | [redacted] |
| Submitter organisation | Music Therapy NZ |
|  |  |
| This submission was completed by: *(name)* | [redacted] |
| Address: *(street/box number)* | [redacted] |
|  *(town/city)* | [redacted] |
| Email: | [redacted] |
| Organisation (if applicable): | Music Therapy NZ, [www.musictherapy.org.nz](http://www.musictherapy.org.nz)  |
| Position (if applicable): | Chair of Council |

Are you submitting this *(tick one box only in this section)*:

[ ]  as an individual or individuals (not on behalf of an organisation)

✔ on behalf of a group or organisation(s)

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission, and your name(s) will not be listed in the published summary of submissions, if you check the following box:

✔ I do not give permission for my personal details to be released.

(The above information will be taken into consideration if your submission is requested under the Official Information Act 1982.)

Please indicate which sector(s) your submission represents
*(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

✔ Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation ✔ Other professional association

[ ]  Professional association

[ ]  Academic/research [ ]  Other *(please specify)*:

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

|  |
| --- |
| * This still seems primarily a medical rather than patient-centred model of care.
* Families and carers (not just individual patients) need support.
* There is an absence of recognision of the importance of all allied health services.
 |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

|  |
| --- |
| * There is an absence of reference to allied health professions – who should be an integral part of a patient-centred biopsychosocial model of care.
* We need all communities to be more disability friendly – e.g. everyone needs to be educated about the needs of people with dementia or aphasia.
 |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

|  |
| --- |
| * “A comprehensive range of health and disability services” needs to include specific reference to allied health professions including self-regulated newer professions such as music therapy, arts therapy and counselling, which have the potential to contribute significantly to patient, family and community wellbeing across the lifespan.
 |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

|  |
| --- |
| * There is insufficient detail in the strategy about how this will be co-ordinated and funded.
 |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

|  |
| --- |
| * Insufficient detail in time frames and funding
* Lack of awareness of allied health services
* Many health needs are multi-faceted and interconnected – allied health professionals can support the more holistic services needed.
 |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

|  |
| --- |
| * Shared electronic access to patient information – with consent.
 |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

|  |
| --- |
| * Review of professions covered under the HPCA Act and/or equal status for self-regulated professions.
 |

|  |  |  |
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| **289** | Submitter name | [redacted] |
| Submitter organisation | New Zealand College of Clinical Psychologists |

4th December 2015

New Zealand Health Strategy Consultation

Ministry of Health

PO Box 5013

Wellington

**RE: Submission on NZ Health Strategy and Roadmap of Actions**

**Introduction**

The NZCCP represents 723 clinical psychologists and 198 postgraduate students enrolled in New Zealand clinical psychology programs. Clinical psychologists are trained in assessment and diagnosis, formulation (that is, generating a working theory about what has caused and maintains a person’s mental health problems using established psychological knowledge), measurement (using psychometric instruments) and treatment of mental health disorders, and in the assessment of research into the efficacy and effectiveness of psychological therapies and interventions. All have done research at the masters or doctoral level. Clinical psychologists are registered under the clinical psychology scope defined by the New Zealand Psychologists Board; the Health Practitioners Competence Assurance (HPCA) Act 2003 requires clearly specified competences are met and maintained by all registered clinical psychologists; the title “clinical psychologist” is protected by this law. We are bound by a comprehensive code of ethics.

Thank you for providing us with the opportunity to provide feedback on the proposed NZ Health Strategy and Roadmap of Actions. We acknowledge what has been a considerable amount of work to get it ready for consultation.

NZCCP commends the MoH on its approach to the design and development of this plan. Ko tau rourou, ko taku rourou, ka ora ai te iwi – with your baskets of knowledge, and the rest of the sector’s, this plan will flourish and so too will the people.

NZCCP agrees with the system architecture being proposed. The focus on prevention, early intervention and rehabilitation approaches to concentrate effort and ensure results for whānau using existing services, is central to addressing the mental health problems that create sustained hardship and poor outcomes for whanau.

We have opted not to answer your specific questions but provide you with over-arching feedback and specific feedback relating to the clinical psychology workforce.

**What we observed:**

The Ministry of Health has acknowledged in the document that many of the recommended actions are not very different from the current strategy. We realise that proposing detailed and prescriptive solutions is unrealistic but there is a fundamental lack of detail in how the strategy is going to be resourced and implemented and we are concerned that New Zealanders may be no better off five years from now. Unless significant changes are made to the way primary care services are funded and purchased the type and location of services delivered and the health outcome measures will not effectively change.

In addition the references made in the Roadmap of Actions document to solutions being delivered ‘over time’ do not provide adequate outcome measures for healthcare providers. What is needed is a blue print for expectations around timely outcomes, expected health service deliveries and collaboration with other providers so as to avoid a continuation of siloed and inefficient health care delivery.

The initiative of ‘Promoting to service users and clinicians the benefit of having access to a patient portal’ is not robust enough and this should actually be mandated and adequately resourced by the Ministry of Health and uptake regularly measured as health professionals become more familiar with IT.

*Closer to Home*

The Roadmap of Actions document refers to the need to ‘fully utilise health skills and training by removing legislative barriers to allow health practitioners such as ‘pharmacists and nurses’ to prescribe. It is disappointing that the MOH has not considered applying this to other professional groups such as psychologists who are in the process of working towards prescribing scopes of practice.

*Tackle Long Term Conditions and Obesity*

The Roadmap of Actions document refers to the need for health professionals to reorient planning guidance and performance management to either diabetes or mental health or cardiovascular disease. We wish to point out that these conditions are connected, multi-factional and driven by social factors that cannot be siloed.

While we support the proposed actions to “increase the effort on prevention, early intervention, rehabilitation and wellbeing for long-term conditions such as…mental health conditions…” and to “increase support to pregnant and postnatal women experiencing mental health and alcohol and other drug conditions” we are deeply concerned that there are no other references to mental health or alcohol and drug issues in the document. This is a glaring omission in a nation where, among people of all ages, poor mental health, alcohol and drug dependency and the rate of suicide ages is one of the highest in the developed world.

**Value and High Performance**

We are pleased that the MOH has acknowledged the need to ensure funding and information systems support providers to improve their services and it is encouraging that a health investment approach is being considered. However we are concerned that the document does not provide enough of a mandate for providers to invest in systems that are for the good of the nation and will assist health delivery services to be joined up across both care sectors and professional groupings.

We would also argue that purchasing from NGOs and commissioning services at a local level requires sound contract management to ensure deliverables are clear and outcomes are met.

**What is needed for improvement**

The Health Strategy quite rightly proposes that a health outcome focused framework will be developed that will link to the IPIF work already carried out.

NZCCP emphasises that if the MOH want to increase and improve equity of health outcomes, quality and value, clinical psychology services must be incorporated into the primary care delivery model and for this to work there needs to be a health investment approach that is supported by a complete overhaul of the funding model. As long as Doctors remain the financial gatekeepers to the way services are devolved, we will continue to get the same outcomes for patients.

**Making it happen:**

Clinical psychologists are pivotal to the delivery of a number of the actions outlined in the Roadmap of Actions Document. We urge the MOH to consider how clinical psychologists may be better utilised in the development of future primary care models and future funding arrangements.

[redacted]

**President**

**New Zealand College of Clinical Psychologists**

Email: office@nzccp.co.nz

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| --- | --- | --- |
| **290** | Submitter name | Deborah Connor |
| Submitter organisation | Diabetes New Zealand |
| This submission was completed by: *(name)* | Deborah Connor |
| Address: *(street/box number)* | P O Box 12441 |
|  *(town/city)* | Wellington |
| Email: | Deborah.connor@vodafone.co.nz |
| Organisation (if applicable): | Diabetes New Zealand |
| Position (if applicable): | President |

Are you submitting this *(tick one box only in this section)*:

[ ]  as an individual or individuals (not on behalf of an organisation)

√ on behalf of a group or organisation(s)

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[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

√ Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

[ ]  Professional association

[ ]  Academic/research [ ]  Other *(please specify)*:

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

|  |
| --- |
| The NGO sector has potential to do more in the health space if appropriately resourced. There is an opportunity for this sector to do more in the prevention, awareness and support areas. The NGO sector needs to be identified as a core member of the ‘one team’ alongside the wider membership of the health system. A challenge for our health system that should be noted is recognising that, particularly when considering long term conditions and prevention work, we are investing time and money now but are unlikely to see the full benefit for many years to come. This is a challenge when it comes to making funding decisions.  |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

|  |
| --- |
| The statement captures in essence a desirable health system where the environment encourages good health for all, but good health services exist for the occasions they are needed. The ‘smart system’ is the primary enabler so needs to happen early in the journey.  |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

|  |
| --- |
| The principles will be useful to guide the implementation of the Strategy. The emphasis needs to be whole system change not just health system change.Attached to these principles it would be useful to have some specific short and long term goals and targets defined. These should be focussed on the underlying things that will potentially impact the most on our populations health e.g. lifestyle change (diet/physical activity/smoking status…) |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

|  |
| --- |
| There is always a balance that needs to be struck between what is desirable and what is affordable. The 5 themes will need to link closely to achieve the central aim of All New Zealanders live well, stay well, get well. The 5 themes will be potentially useful as a decision tool to use to measure possible actions against – the diagram implies that they are weighted equally, and as a guide for targeting efforts.System change will be required at all levels and it will be important that frontline workers in all parts of the system have an understanding of what the strategic themes mean. It will be important that a clear and concise one or two sentence explanation is communicated of each of these themes.The concept of one team is important and it is important that this team goes beyond health professionals and scientists and includes consumers themselves. There is a need to develop effective consumer representation and for this to be at all levels of the system.  |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

|  |
| --- |
| The illustrative Implementation diagram on page 29 is a good pictorial of the journey and will be a useful planning tool where more detail of specific local actions can be added under the bullet points.  Our hope is that these will be seen as the starting points only and that the pieces of work like the integrated health record that will be being used by 10 DHBs in 2018 will be available nationwide by 2021 and covering all New Zealanders not just pregnant women and children - the diagram does not currently make this clear. |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

|  |
| --- |
| Different areas of New Zealand face different challenges , so it will be important that this is taken into account and support is tailored and specific to need. These include things like urban v rural population mixes, ethnic and age diversity and socio -economic issues. What may work extremely well in a Counties Manakau setting may be quite ineffective and uneconomic in a rural Southland setting.In terms of tracking and reporting the Atlas’s of Healthcare variation, produced by HQSC have the potential to provide useful outcome and trend data. The range of Atlas’s is growing and the information provided at both a National and DHB level.KPIs and Outcome measures should be built into all project/proposal/service design at the start, bearing in mind the returns on investment may not be fully realisable in the short term.We should also look to sharing and communicating overseas best practice so this can be used to inform what is done at an operational level. For example a huge amount of work has occurred internationally that has established the clinical and cost effectiveness of lifestyle interventions for delaying and preventing the onset of Type 2 diabetes. This research should be, and is, informing translational research efforts in New Zealand.  |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| --- |
| Diabetes New Zealand looks forward to working as part of the team to build and operationalise the detail underneath the strategy that will impact positively on the lives of people and their whanau within New Zealand affected by diabetes. |

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| **291** | Submitter name | [redacted] |
| Submitter organisation | Ruapehu District Council |

Our Ref: 618875

File: H40-0022

04 December 2015

**To:** New Zealand Health Strategy Update Consultation

New Zealand Health Strategy Team

 Ministry of Health

 PO Box 5013

 Wellington 6145

 nzhs\_strategy@moh.govt.nz

**Subject:** **Ruapehu District Council Submission on the New Zealand Health Strategy**

**Submission from:** Ruapehu District Council

 Private Bag 1001

 **TAUMARUNUI 3964**

**Point of Contact:** [redacted]

Council does not wish to speak in support of its submission.

**1** **INTRODUCTION AND SUMMARY OF MAIN POINTS**

## ***1.1 Ruapehu District Council (RDC) appreciates the opportunity to submit on the New Zealand Health Strategy. RDC supports many aspects of the strategy and would like to commend the Ministry of Health (the Ministry) on the work that has gone into it, particularly the focus on the decentralisation of some health services.***

**2 THEME TWO: “CLOSER TO HOME”**

2.1 As a rural district, we endorse Theme Two; “Close to home”. Specific characteristics of this theme that are important to communities within the Ruapehu District include the encouragement of shifting skills and technologies, minor surgeries and intravenous antibiotics, closer to home in primary and community care settings.

2.2 RDC would like to bring your attention to paragraph seven, page 14;

2.2.1 *“For those that live in remote locations or who are unable to reach health services, we can use other approaches. These include the use of telehealth, mobile vans and out-reach clinics.”*

2.2.2 RDC is bringing this to your attention in order to highlight the reality of the situation. Those who live in remote locations will most likely not have access to, or the ability to use, the telehealth system. There are many parts of the Ruapehu District that cannot connect to the most basic internet connections such as dial up. While we acknowledge that this issue directly correlates with your vision to coordinate with other governmental agencies, it none the less is a crucially central consideration when claiming that telehealth is an accessible solution.

2.3 The Ruapehu District comprises of many communities with a high number of Maori rangatahi. RDC, therefore strongly support the continuation of investment into Tamariki Ora and B4 School Checks. These services are exceptionally important to our tamariki as it is an important investment into their future.

2.4 Theme Two’s Roadmap of Actions states; “Strategic planning will be done regionally, and there will be stronger advisory support for determining and managing the implementation of regional services”. While RDC endorse Roadmap Actions three through to six that address this goal, we would like to stress the importance of getting this ‘right the first time’. RDC would like to suggest that ‘regional’ health service planning be brought down another level to ‘district’ or even ‘town’ health service planning to ensure that the right services are available in the right community.

.

**3 THEME THREE: “VALUE AND HIGH PERFORMANCE”**

3.1 RDC supports Theme Three; Value and High Performance. One particular characteristic of this theme that reverberates within Ruapehu communities includes the objective of “striving for equity of health outcomes for all New Zealand populations”.

3.2 RDC supports your commitment to reducing inequalities between different demographics. We would like to see a further reduction in the inequalities between those living in cities and those in rural and regional New Zealand.

3.3 Theme three covers the cost of failures to ‘the system’, however, this strategy as a whole does not cover the cost of failures and inadequacies of the system to rural New Zealanders.

**4 THEME FIVE: “SMART SYSTEM”**

4.1 RDC supports Theme Five in theory, however, we would like to point out that rural communities will face considerable disadvantage if extra resources are not invested into rural communities to bring them up to speed with the rest of the nation in terms of access to technology, broadband and mobile reception.

4.2 Improving health care accessibility, quality and management will benefit Ruapehu communities. It will however, only benefit Ruapehu communities that have adequate access to their online profiles or other proposed ‘smart systems’. As stated earlier, this element of the Ministry’s future direction is vastly dependent on other governmental organisations and the timeliness of investment into rural broadband and mobile blackspot infrastructure.

4.3 RDC strongly supports Roadmap of Actions 18 through to 20. In order for these actions and ‘smart systems’ to succeed in rural and regional New Zealand, a serious investment into broadband and mobile blackspot infrastructure will need to take place so that all New Zealanders can benefit from such health care technology.

4.4 It is important to RDC that the inequity faced in rural communities by nationally disproportionate access to the internet is acknowledged. This gap needs to be fixed before a ‘smart system’ is introduced so that the health of rural New Zealanders does not continue to suffer and fall further behind that of their peers in the cities.

Samantha Arthur-Curtis

**POLICY ANALYST**

|  |  |  |
| --- | --- | --- |
| **292** | Submitter name | [redacted] |
| Submitter organisation | National Cancer Consumer Representative Advisory Group |

New Zealand Regional Cancer Networks (NZRCN)





30th November 2015

New Zealand Health Strategy Consultation

Ministry of Health

PO Box 5013

Wellington

Dear Sir / Madam

**Feedback on draft Health Strategy**

The National Group is grateful for the opportunity to contribute to the feedback on this strategy. The National Cancer Consumer Representative Advisory Group is made up of eleven members representing the regional cancer network consumer groups, Maori and Pacific and non-government organizations. Established in 2011 two of the objectives of the group are:

* To provide effective leadership for cancer consumer representation in New Zealand
* To function as a trusted advisor to the cancer control sector

Being able to provide advice and guidance to the Ministry on work such as this supports our objectives.

The National Cancer Consumer Representative Advisory Group concurs with the aims of the Strategy and the identification of specific actions to implement them.

Our feedback is below, structured under the section heading and page number.

**Why a Health Strategy?** (page 1)

We support a shared view approach to improving health care in New Zealand and ensuring that we have a sustainable and future proofed health system.

**Health in its wider context** (page 3)

We feel that the proposed Strategy should improve health and well-being and reduce inequities’ however we note that this is a high level Strategy and the detail of any implementation of the Strategy should assure us of this.

**Strategic Themes** (page 10)

We believe the five themes are essential to the implementation of the Strategy.

**Closer to home** (page 14)

This theme addresses the reduction of inequities but we note that equity must be considered in terms of socio-economic status, cultural and other health issues that may be a barrier to meeting this objective.

**One team** (page 21)

We support a one team approach which includes the individual and their whanau. We can no longer tolerate or sustain siloed approaches to health care.

**Smart System** (page 24)

We acknowledge Information Technology as the key enabler to health gains and new models of care.

Shared Care Plans (page 25) are one mechanism that allows the individual to interact with their health information and their care team. We would like to note that health navigator roles do not necessarily need to sit within a clinical space and this opportunity should be explored.

**Overview of the New Zealand Health and Disability system** (page 28)

The figure correctly identifies that New Zealanders are at the heart of the health system. A person-centred approach to health care should see the individual being asked “what matters to you” as opposed to “what’s the matter with you”.

**Roadmap of Actions** (page 30)

The language of the document reflects the inclusive direction that health care is moving to, for example ‘people powered’ is indicative of a collective responsibility to health and well-being.

**Action 8** (page 40)

This action referring to health outcome-focused framework most closely aligns to the Strategy’s central objective that ‘all New Zealanders live well, stay well and get well. It deserves prominence in the list of actions.

**One Team** (page 42)

Under bullet point one we would like to see the term actors replaced with something that doesn’t suggest that this is a stage play.

**General Comments**

The concept of ‘all New Zealanders live well, stay well and get well’ misses one fundamental part in that we also want New Zealanders to die well. Commentary around dying is missing from the Strategy and yet it is the one certainty that we all have.

We are looking forward to an implementation plan that will show how the action areas are to be achieved, and timeframes for meeting the goals. Strong leadership and governance is needed to ensure the success of the Strategy.

We would like to have an understanding of how new initiatives will be funded and how any funding is sustained. We note caution that the efficiencies suggested in this Strategy may not be sufficient to match current economic constraints. One area that has been listed as a strength is New Zealand’s no-fault accident compensation system however we note a trend to erode previously traditional areas for ACC cover. This is turn places additional pressure on the public health system.

Transparent evaluation of the action areas of the Strategy is needed.

The Strategy does not explicitly reference consumer involvement. It would seem to be essential to achieving the people powered them; to achieving the vision ‘what do we want in 5 years (page 40) and them 4 – one team. Consumer involvement should be made explicit in the appropriate action areas.

Once again thank you for the opportunity to respond to the draft Health Strategy.

Kind regards

[redacted]

Chair

National Cancer Consumer Representative Advisory Group

|  |  |  |
| --- | --- | --- |
| **293** | Submitter name | [redacted] |
| Submitter organisation | The National Health IT Board Consumer Panel |

4th December 2015

Draft Health Strategy Consultation Group

Ministry of Health

PO Box 5013

Wellington 6145

Dear Sir/Madam

**Feedback on draft Health Strategy**

The National Health IT Board Consumer Panel (Consumer Panel) is pleased to have the opportunity to comment on the draft Health Strategy.

**About the NHITB Consumer Panel**

The National Health IT Board (NHITB) is a subcommittee of the National Health Board charged with providing leadership on the implementation and use of information systems across the health and disability sectors. The NHITB provides independent, strategic advice to the Minister of Health, and the Ministry of Health.

The NHITB established a Consumer Panel to ensure access to consumer perspectives for its projects and committees. The purpose of the Panel is to contribute a consumer perspective to the NHITB and all governance or working groups engaged in delivering the National Health IT Plan, with particular emphasis on Shared Care initiatives.

The Panel has ongoing working relationships with other groups, organisations and people involved in overseeing and delivering aspects of the National Health IT Plan, including the parallel National Information Clinical Leadership Group (NICLG), and the Health Information Governance Expert Advisory Group which is charged with providing an IT Governance Framework for health.

**Consumer Panel Principles**

The fundamental principles for the sharing of personal health information should reflect those in the founding document of Aotearoa, the Treaty of Waitangi. It is important that sharing health information is seen as a partnership, that both the process and the information are protected, and that participation is key. Consumer perspectives should be part of every decision to honour and validate a co-design approach to health care, including co-design of the information systems and related activities that support the provision of health care (NHITB Consumer Panel, 2012).

The OECD has identified eight mechanisms for data governance with one being that the public are consulted upon and informed about the collection and processing of personal health data. We strongly support this principle. While it is reflected in the draft Strategy the Panel believes there must be a real commitment from the Ministry to involving the public and not just the Panel, as significant initiatives to IT information sharing are developed.

**Panel members’ general response to the draft Strategy**

We have provided a range of general responses to the draft Strategy as discussed by the Panel, followed by specific reference to the Strategy.

1. The document is very light on its reference to those in the community who live with disabilities. In 2013 24% of the population reported that they had a disability. Given this information there needs to be greater visibility of disability within the Strategy.
2. New Zealand has a high suicide rate with around 500 people each year successfully suiciding and many more attempting suicide. We believe mental health and well-being needs a higher priority within the Strategy. Our views are supported by Dr John Crawshaw (Ministry of Health’s Director of Mental Health) who as recently as the last weekend, referred to mental health as a high priority.
3. Reference to the workforce is lacking particularly in respect to cultural competency. In this multi-ethnic country it is particularly necessary to ensure that the workforce are able to recognise and work within a multi-cultural environment that allows the consumer and the health care provider to be safe.
4. Oral health is not recognised within the Strategy. Research published through the University of Otago identified that improved oral health has also contributed to improved mental health and quality of life for a small group of Maori mental health patients (Steinman et al, 2013). Good oral health is also important for pregnant women and people with diabetes. We would like to see reference to improved oral health services for all New Zealanders within the Strategy.
5. We note that maternity services are recognised as an early investment opportunity which will support the future well-being of children, parents, families and whanau. We emphasise that there needs to as much concern for the health and well-being of the pregnant woman as well as the fetus/baby/child. This must not be over-looked in the push to improve outcomes for the child.
6. While supporting the Strategy in principle we wonder what impact changing governments with different priorities and policies may have on the Strategy.
7. We note [on page 13] that within the vision is the ability for people to access practical information in order to make choices. We would like this to be explicitly referenced to improved health literacy and included on page 33 under “what do we want in 5 years?”
8. The ongoing development of the workforce will be one of the greatest enablers to health and well-being improvement. The Strategy reflects on the need for training and education. Additionally the Strategy needs to include up-skilling and continued education to enable health professionals to work competently to the top of their respective scopes of practice or any new expanded scope of practice. This needs ongoing resourcing.
9. We support the removal of legislative barriers to allow health professionals to practice to the top of their scope or expanded scope. We note that this is already in train but there appears to be a lack of a good funding structure in either primary or secondary care to support these new roles and/or enable them to work optimally.
10. We support care closer to home. We note that the transition between services needs to be managed well with transfer of care plans available to the individual and their care team, ideally electronically but on hard copy for the individual if that suits them best.
11. Providing services closer to home must reflect communications with health care providers so they are aware of the range of health and social services available locally.
12. The Strategy lacks any dialogue around dying well and that includes access to excellent palliative care. Death is the one certainty that we have with any person’s health and well-being journey.

Health in its wider context

The Panel are cognizant that the current government direction is following an international trend to share data to develop population health and social profiles. The intended benefit of sharing of health and social data is noted as improving individual health care, higher quality care and more efficient services. We note that the provisions for privacy, confidentiality and security of personal health information should aim to ensure that all people using health services are confident that any concerns they have about information sharing or the security of their health information are met. No person must ever avoid seeking advice about their health care and / or receiving necessary treatment due to concerns about information sharing or the security of their personal health information (NHITB Consumer Panel, 2012).

Privacy is crucial because it facilitates and promotes values such as autonomy, individuality, respect, dignity and worth (Consumer Panel, 2012).

There has been a lack of public engagement regarding the existing social sector initiatives that discusses how data will be accessed and shared, where it will be stored and how long it will be retained, and the purpose(s) to which the combined information will be put. Within this wider context, we are concerned and keen to understand how health information may be presented and shared and if it will be interpreted by people who are not registered health practitioners, or who have no expertise in health.

The future we want and the refreshed guiding principles

We support the statement “aligning behaviours - from fragmented health sector silos to integrated social responses” in principle but the way that it is done will be critical. It will need to be managed carefully and thoughtfully and with consumer engagement and involvement at the outset and ongoing, in governance, reporting and monitoring, and evaluation.

We see a risk in the collection of data becoming all consuming and “sucking up” huge investment for surveillance only without consideration being given to investing in wrap-around services that may be identified as a need through the data collection.

Principle eight states “thinking beyond the narrow definition of health and collaborating with others to achieve well-being”. An enabler to this, via technology, is the use of role-based access to personal health information. This will provide a level of confidence that only those that should be, are accessing our personal health information. Research has identified that individuals had some reluctance to share general health information and a greater reluctance to share sensitive health information. There runs a risk of incorrect, non-factual information being placed on health records, or information being withheld by the individual. Role-based access should be defined at a national level and be reflective of differing access levels, dependent on the user’s role. Sitting alongside this must be a robust audit trail that allows the individual to see who has accessed their information. Access must be based on the health care provider’s role within their organisation, their profession and their relationship with the individuals care (NHITB Consumer Panel, 2012).

A single national confidentiality agreement reinforcing codes of conduct to cover all agencies and individual who will have access to personal health information. We have concerns around the unregulated workforce, within and outside the health sector, who may have access to personal and sensitive information who may not have sufficient appreciation of the need to protect that information.

We acknowledge that there needs to be respect in terms of collaborating with others. Just as social sector agencies would like to utilize health information we acknowledge that the use of social sector information could be beneficial to understand the health and well-being of individuals and their whanau. To that end, there must be surety around the collection, privacy, storage and disposal of personal health information.

We would suggest that the most appropriate approach to sharing of information is by involving communities. Working with communities so that a collective decision can be reached about the purpose of data collection, and monitoring results to ensure there are positive outcomes for the communities. We propose a cautious and respectful approach to using health information particularly where that information is to be shared with agencies outside of the health arena.

People - powered (page 11)

With reference to bullet point one “understanding people’s needs and wants and partnering with them to design services to meet these”, we hear rhetoric about designing together however seeing it in practice is not so obvious, not just services but IT projects also. The ability to design together comes with leadership and therefore we endorse the need to develop leaders both within the health system and within communities.

The Health Quality and Safety Commission published a guide for District Health Boards to engage with consumers. The guide was developed with consumer involvement and we would support wider acknowledgment and use of it.

Closer to home (page 17)

The wording of the statement “Well designed and integrated pathways for common journeys” is not liked. The use of the word 'common' risks demeaning the pathway from a patient's perspective. For example, the breast cancer pathway may be common, but it is unlikely to be common to the woman so it is important that the care provided to her meets her specific needs.

We are aware the IT will be the enabler to the development of clinical pathways. We would support the development of patient / consumer pathways alongside the clinical ones. We considered the role of standardised clinical pathways to support a transparent pathway for providers and service users. Whilst this has the potential to reduce inequities and improve quality in health care we are aware that health professionals need to still have the ability and freedom to ‘think outside the box’. Outlier patients will present and it is important that clinicians are not bound by standardisation.

With respect to the last bullet point on page 17 commencing “ the health system works effectively .....: ‘ the ideal is to have a level of trust between consumers, health and social agencies that gives consumers confidence to share information for the purpose of good health outcomes. We caution that the apparent high level of trust should not be taken for granted. It may take only one significant privacy breach to damage trust indefinitely.

Value and high performance (page 18)

We note that the word poverty has been replaced by ‘financial factors’. What is meant by 'financial factors'? Is it poverty at an individual/family level, or insufficient resourcing via Vote Health? Please clarify.

Page 19 has a commentary around Pharmac being ‘world leading’. Any new health care initiative needs to be established to meet New Zealanders' needs in the first instance. If the system happens to be world leading that is a bonus. 'World leading' should not be the driver for the initiative.

The theme of the focus on outcomes excludes a positive experience of dying. We need equity of access to palliative services and to ensure that all New Zealanders die well.

Page 20 - bullet point commencing “the health system has an operating model ..” needs to include consumers as part of the development of any solution. Public/consumer involvement in these processes has been promoted for many years, including the NZ Health Strategy of 2000. However this involvement has been variable. Some agencies don't see the value consumers add so haven't bothered; while some consumers haven't known how to get involved. We need to start changing the public mindset so that they expect to be involved if the goal is patient-centred care and improved outcomes.

In a similar vein, responsible authorities for the regulated workforce (e.g. Medical Council) should have someone with a strong consumer/patient perspective on their respective governance bodies and look to involve consumers in their policy development, guidelines etc

One team (page 21)

We support a one team approach where that team includes the individual (and their whanau if they choose), with visibility of who the members of that team are. This focus area calls for an evaluation of initiatives to ensure that the purposes are being met. Any evaluation process should run alongside programme development and should include all team members including the consumer (or their representatives).

The OECD paper (2015) reflects the need for Health Ministry leadership to ensure that data is managed and is at the forefront of government policy and action (p 20).

We did not all agree as to what a ‘culture of enquiry’ on page 23 meant. There is an opportunity to include more clarity. Is it stating that all stakeholders including researchers, statisticians, relevant government agencies, health providers, consumers/the public should be asking questions and challenging results? If that is what is intended then we support this.

Smart system (page 24)

What happens if health care providers do not want to share data or do not have confidence that shared data will be handled with due care.

The generation of data for the purpose of improving health systems must be done in consultation with the public (Ubaldi, 2013). We note that in the recent OECD paper on Health Data Governance it refers to New Zealand as being one of the countries with the highest levels of data accessibility and data sharing, and yet we have done so without any over-arching information governance framework in place. It is imperative that a governance framework is implemented and audited before we consider any wider use of health information. The Consumer Panel identified robust governance as a key expectation in the use of electronic personal health information

Ministry of Health must be seen to be modeling best practice with respect to health information governance. Providing strong leadership, robust and transparent governance will give the public a level of confidence that their personal health information will be held securely and used/re-used appropriately. Robust governance will mean the public can trust the people and the mechanisms that have stewardship of this information.

We note that there is a need to continue further research into the health and wellbeing of New Zealanders. One mechanism to doing this is to use de-identified population data. Given the technological advances of today there needs to be surety around the process of de-identifying data. In a speech given by Professor Fred Cate to members of the public late May 2015 he highlighted the fact that it is now becoming increasingly possible to identify individuals through the collation of a stream of previously de-identified health and social data.

We also note that the current review of the Privacy Act 1995 is looking to legislate against re-identification of information. The OECD paper (2015) dedicates a chapter the de-identification (and potential re-identification) of personal health data. They note the gaps between legal requirements and de-identification in practice. We must get this process right in order to give certainty to the wider public.

General Comments

Consumer consent to the sharing of information is imperative and this is reflected in the OECD paper (2015) which highlights the risk of loss of public confidence in government and its institutions should there be a failure in the privacy and security of our health information. Any change to the sharing of health information requires transparency and consultation with the public.

Roadmap of Actions

We acknowledge that this is a high level strategic document and that the operationalisation and implementation of the actions still requires a great level of detail around it. We also note that the roadmap of actions is aspirational however that is required in order to ensure a new sustainable and equitable health system for all New Zealanders.

Action 1 (c). Telehealth will enable better interaction with health care particularly for those who have to travel far for health services. However ultra fast broadband across the country needs to be assured.

Action 6. While supporting a cautious and considered approach to cross-sectoral sharing of information any data that is produced must also have narrative around it. Data without this does not paint a true picture.

Action 19 (b). We support the continued push for all New Zealanders to be able to access their patient portal electronically. Aligned with this we mustn’t loss sight of the development of the maternity portal given its promotion with the development of the Maternity Systems programme of work.

Action 20. These actions tend to suggest that every research project will demonstrate a positive outcome and that outcomes will be rolled out across the country. This may not be the case. We note that the driver for research should not be solely for an economic benefit versus health outcomes.

To summarise, the Panel are supportive of the draft Strategy in principle. We see the greatest enabler to a new health system being the use of technology at a multitude of levels and therefore we acknowledge the need for multidisciplinary leadership and a health IT Governance Framework that is measurable, evaluated and auditable.

Again thank you for the opportunity to provide feedback on the draft Health Strategy.

Kind regards

[redacted]

Chair

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*(you may tick more than one box in this section)*:

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[ ]  Education/training [ ]  Local government

[ ]  Service provider [ ]  Government

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[ ]  Primary health organisation [ ]  Other professional association

X[ ]  **Professional association**

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## Consultation questions

These questions might help you to focus your submission and provide an option to guide your written feedback. They relate to both parts of the Strategy: I. Future Direction and II. Roadmap of Actions.

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| Yes, a need to be more explicit in regards to investment of health care for children and youth. There is an implied assumption that children and youth do not experience long term chronic conditions and disabilities to the same extent as the adult population. Not so; in reality this vulnerable population is dependent on parents, carers and wider community to provide additional help and an environment that enables best health and optimal development. However, this critical dependency is not recognised in the drafts. Therefore, in the future when strategies are translated into action these vulnerable population groups will be disadvantaged if there is no explicit message. Currently this inequity is already a challenge; e.g. Paediatric Palliative Care funding is inequitable compared to the considerable investment in adult palliative care, even though MOH documents and guidelines support improved practices; disability services for children and youth have to compete with an ever increasing demand for adult services therefore quality of life (for ALL NZers) is inequitable. Equity of funding, and the process of decision making, across the spectrum of early interventions and support services, have huge impact on long term health outcomes and quality of life. The children of today are tomorrow’s future and the need to have a lens on how services for children are funded, on a population basis, needs to be articulated and be more visible in future strategies.  |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| While the words ‘All New Zealanders’ is noted the themes throughout the document mainly focus on adults and the elderly. Children and Youth must be more explicitly protected in the document. They are not appendages of adults, despite being dependent on adults. If we ignore the needs of children and Young people by subsuming them in the needs of adults we will do harm, fail to appropriately prioritise their health and wellbeing when they are the future of our country. Furthermore New Zealand is expected under the UN Conventions of the Rights of Children to acknowledge, promote and protect the needs and interests of children and youth.We strongly recommend there is a Minister for Children. Rationale; As children are reliant on their parents and carers, are non-voters and do not have a dedicated voice around the government’s cabinet table there is a need to have a child impact lens applied to the raft of legislation that has direct and indirect impact on children lives and wellbeing; e.g. housing, education, social services, employment, local body requirements and a range of other environmental and infrastructure decisions that impact on the health and well-being of children. A Minister for Children would significantly help address this inequality and ensure comprehensive investment (across ALL sectors) in future New Zealanders. The Commissioner for Children is a valuable asset in advising Government but does not have the required Executive power that a Minister within Cabinet would bring to bear to ensure the interests of children have appropriate focus. |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| Yes, provided they are viewed within the wider context and that ‘All’ is more than adult services.Again we urge that children are explicitly stated within the principles to ensure they receive appropriate attention in policy, planning, and purchasing of future national health services.  |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| The pace of change is rapid and, as high level statements, they are comprehensive. The reality however, lies is in the translation of words to frontline practice. For example technology is great but children don’t use this to access services and are therefore dependent on parents to do so. Also, as children have no voter status this makes the group even more vulnerable to being overlooked in planning and funding of services. A minister for children would provide a critical lens to look at the impact of increasing technology on health services for children and on the equity of health and development outcomes.Closer to home: for early community-based interventions this is fine, but what about the increasing home based care for life limiting conditions and disability services for children and ensuring an equitable funding formula? (e.g. paediatric palliative care needs, chronic health and disability conditions, the increasing obesity rates and subsequent impact on children – these are just some examples). We recommend the themes are more explicit about investment in child health and consider the contexts that enable best health and development.  |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| On paper this looks good however, the translation from words to practice is more than likely to be another story as the pressures of adults’ health needs overtake and reduce investment in child health. Currently this is a commonly encountered scenario. Without an overarching ‘child focused lens’ and ‘impact review’ process we believe the threat to adequate child and youth health investment will persist. As noted in Box 4 (above) there is a need to be more explicit about the investment across all child health needs; this is more than early interventions, health promotion and the investment in the Children’s Action Plan. Adequacy of investment should be considered across the whole system of care.  |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| Support the increasing range of clinical networks that have both a vertical and horizontal focus in regards to integrations and co-operation between multidisciplinary groups and organisations. Invest in IT systems that can track incremental change and provide progressive updates on developments, integrated and shared learning programmes and patient satisfaction stories. Acknowledge that change takes time, especially change that requires professionals to work together for the benefit of the patient (and family). Reporting on ‘health outcomes’ is a challenge and will take time to profile effectively. Include children and youth as participants in their health care and develop ways to hear their voice through the services. |

### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| We commend MOH for pursing this review and updating the Health Strategy; it’s long overdue, and the myriad of gaps and needs identified are many. We join colleagues in wanting to maximise the opportunities to move to an improved health service that requires significant culture changes from traditional ’ways of working’ that frequently (currently) include ‘patch protection’ behaviours. We firmly believe the future health of all New Zealanders sits with the younger generation. A dedicated focus on child and youth health and development, across all sectors and legislation, needs to be developed to realise our future health aspirations.  |

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| **295** | Submitter name | Sarah Walmsley |
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[x]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Pharmacy professional association

[ ]  Primary health organisation [ ]  Other professional association

[ ]  Professional association

[x]  Academic/research [ ]  Other *(please specify)*:

### Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?

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| We feel that a focus on the modern health consumer is missing. There is a broad and growing body of evidence that describes the patient-related factors that influence health outcomes, and we believe these should be understood and addressed as part of health service provision and modelled for their impact on lifetime health costs.We also feel that the impact of e-Health and Telehealth interventions has been undervalued. These solutions improve access to patients and reduce costs considerably for the healthcare sector. Furthermore, the content of these interventions is critical, and should address the full biopsychosocial experience of living with disease.How a patient perceives their illness and its treatment can directly impact their health-related behaviours (such as taking medicine and engaging in appropriate self-management such as attending appointments, eating well and exercising) (1) therefore profiling patients for their individual beliefs and barriers can help to guide appropriate and relevant interventions. Research has demonstrated that tackling a person’s individual beliefs can result in improved clinical benefit and QOL outcomes. For example, people living with COPD are more likely to be adherent with medication and exercise, and have more positive psychological outcomes if they understand the variability of symptoms and have greater perceptions of personal control. These perceptions can be improved by participation in appropriate rehabilitation programmes, and by addressing the patients’ illness perceptions (2). Furthermore, targeting illness perceptions by provision of a psychological intervention improves psychosocial functioning, including return-to-work in patients post-MI (3). Illness perceptions also predict adherence behaviour and physiological outcomes for people living with Type 2 Diabetes, where greater congruence and understanding of consequences of the disease, coupled with higher levels of self-efficacy improve management of HbA1c (4).Other patient factors are important, and must be considered to ensure successful outcomes, for example patients’ access to technology and indeed their ability to receive interventions in or close to home. Promisingly access to technology and smartphones is equitable across social groups in New Zealand, transcending cultural and socioeconomic barriers (see NZ Census, 2013). Therefore utilisation of technology allows the vast majority of patient groups to access healthcare where they work, live and play.Research demonstrates that the impact of psychosocial factors on illness and recovery can be significant, so again we propose that factors such as access to social support and psychological comorbidities common in physical health such as depression and anxiety are included in patient profiling, and appropriate support included in the provision of healthcare. Finally, those people that provide unpaid care for someone with a long-term disease (often a close family member) must also be acknowledged and supported to ensure the negative impacts of caring (for example for a person with dementia) does not add additional cost and burden to the health system. Caregiver burden, compassion fatigue and burnout are all very real issues that can be alleviated by the provision of appropriate support and skill building. This can be delivered again through eHealth and Telehealth channels, so that no carer is precluded from accessing this level of care. |

### The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

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| Include the word ‘empowered’ or ‘enabled’ or ‘active partners’ in their wellness for example ‘So that all New Zealanders are empowered/enabled to live well, stay well, get well’ which reflects that people should be encouraged to take a more active role in their own healthcare and that their individual needs are met. In this way the system will naturally lean towards a patient-centred model, recognising that service provision should be allocated and delivered in a way that meets an individual’s needs, with a focus on self-management and those individuals who are caring for and responsible for other family members. One smart system should undoubtedly include greater provision of eHealth and Telehealth solutions, as this improves access to and delivery of healthcare across New Zealand, and broadens the offer to address the full biopsychosocial nature of disease. |

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

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| Yes, under principle 8, recommend using terminology such as ‘thinking beyond narrow definitions of health and moving to a biopsychosocial model of healthcare and integrating with social and community services…’  |

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?

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| This section sounds very promising, and one might argue – rather optimistic. It is difficult to see how the vision in each of the sections will be realised. In addition to further clarity on **how** to achieve success (and how it would be measured) we would like to see more evidence of the barriers or challenges that would prevent us from achieving this future state and approaches for how these would be addressed. Finally some clear conclusions on a staged/prioritised approach – that emphasises focus on the ‘must do’ areas first.We would like to see a clear roadmap that starts with identifying the predictors of poor health outcomes and then utilises evidence-based and best practice approaches to guide service delivery. In our experience some of the For example developing a framework approach for the target disease areas and quickly and effectively transitioning from a research setting or local pilots to scaling up to real world implementation in the wider health system.It might be helpful to identify the building blocks that span all themes. For example, a better performing health system requires a sea change in the way providers of healthcare view the needs of patients and their families. Communication with patients also requires rethinking and retraining and involving patients in the redesign of services and solutions is essential to ensure maximal cost-effectiveness of the health system. We believe one part of the solution would be a technology system that can manage the thousands of interactions that would be required to enable efficient service delivery between primary and secondary healthcare (and all other related providers), and with the health consumers themselves.To achieve ‘closer to home’, digital technology can fill a gap. There is plentiful evidence that eHealth (including text message interventions) and telehealth interventions designed by behaviour-change experts can affect positive behaviour change and achieve health outcomes (see Head et al., 2013). This is an expedient and cost-effective way of achieving good health outcomes across populations, and can be easily delivered to scale in New Zealand. |

### Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

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| We feel that the roadmap of actions should include some sort of priority and chronicity – showing which actions are critical and therefore must be addressed first. The roadmap needs more specificity on how the actions will create positive impact to the health system and how the actions will be measured for success. Otherwise it is possible that many and varied changes could be implemented, without a clear understanding of which are responsible for outcomes. These actions need to be tied to the value imperative – with a case for how the cost of the actions relate to the performance and future cost to the system.Additionally there are some initiatives that will impact on the other strategic themes – particularly the provision of a unified, interconnected technology that can not only house data and trigger clinical activities, but provide for the delivery of individualised patient interventions. |

### Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

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| * Create a transparent incentives framework that drives the appropriate behaviours for delivering a cost-effective health system that delivers the optimal patient experience
	+ Identify key outcome measures (note – the outcomes should be measured, not the activities that help achieve them – e.g heart and diabetes checks do not necessarily reduce cost and improve outcomes) and reward DHBs/PHOs for achievement of these
	+ These measures should include patient satisfaction
	+ For example if patient portals have demonstrated benefits to the cost-effectiveness of the system, GP clinics should be incentivised to drive uptake and ongoing engagement with portals
* A consistent framework for understanding the patient journey through the healthcare system – mapped by disease area, and including the following for consideration:
	+ Patient-related factors as discussed above and interventions to address the negative impact (as discussed above)
	+ System-related factors and service redesign to address the impact
	+ Health-economic factors (scenarios where cost is driven up – e.g post-MI cost of second event, preventative measures and impact to other budget areas, e.g medicines utilisation)
* Co-creation approaches with patients to rethink and redesign service provision (including opportunities for eHealth and telehealth as discussed above)
* Pilot-testing digital self-management support programmes and measuring the health-economic impact
	+ Consider a ‘test bed’ DHB/PHO where a multi-pronged programme can be implemented, e.g implement multiple key initiatives so that performance overall can be benchmarked against other regions – allows for the synergies of multiple approaches to be measured. We believe that it is important to be able to view the impact of the ‘sum equals more than its parts’ programmes
* Coalitions/collaborations between public and private healthcare sector where mutual benefit is recognised to help drive innovation and accountability for outcomes
* Continuous Online feedback mechanisms for consumers to feed back on their experiences and recommend improvements
* Greater involvement of behaviour-change experts in high level decision-making and evaluating and consulting on service redesign
* Change management programme (starting with policy-makers and senior management and driven through every area of the heath system) to support abandonment of a doctor/hospital-centric system
* Greater ability for Primary care to profile for and address all key determinants of health by signposting patients to appropriate support and service – e.g social workers, psychologists and other allied healthcare providers
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### Any other matters

7 Are there any other comments you want to make as part of your submission?

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| * For the benefit of clarity we would like to see that all actions arising from the health strategy leverage the patient role in the success of effective healthcare provision, and recognise that driving behaviour change is central to driving improvements in the health of our nation. Therefore in order to enact behaviour change we need to understand what underpins health behaviours and how to modify these drivers. This is an underutilised lever for achieving better health outcomes, which if incorporated into service design and delivery can not only impact the effectiveness of the system, but improve patients’ satisfaction of the care they receive.
* For each strategic theme include the critical success factors for each, identifying the risks to effective implementation and achievement of outcomes, for example: the effectiveness of an EHR (e-Health record) and provision of digital health interventions depends on high rates of enrolment and patient engagement. Therefore the system for opting patients in (or ideally employing an opt-out approach) to these services and the relevant privacy provisions should be a critical first step.
* Evaluate effectiveness of nationally-funded services such as the National Telehealth Services and direct further funding to these to ensure the best possible service delivery and ongoing reach and effectiveness
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Thank you for taking the time to provide feedback.

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1. New Zealand Oral Health Clinical Leadership Network, 2012. [↑](#footnote-ref-1)
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7. Penno, E. and Gauld, R. (2013) How are New Zealand’s District Heath Boards funded and does it matter if we can’t tell? *NZMJ Vol 126:* 71-84. [↑](#footnote-ref-7)
8. ‘Diagnostic overshadowing’ is a term used to describe a delay in the identification of one problem when it is ‘overshadowed’ by another commonly co-occurring problem. It is also used to describe the misattribution of physical symptoms to mental illness. [↑](#footnote-ref-8)